Form Letter

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MAR 17 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the Director of Marketing at LifeCare Hospitals of South Texas. We provide simultaneous acute medical care and therapy services. Our patients receive the full spectrum of needed services in the same location, and at the same time.

The proposed rule will have a devastating impact on patient access to critical care, and will likely force many long term acute care hospitals to close their doors due to the significant payment reductions.

As you know, long term care hospitals provide acute care services to patients who are demonstrably sicker, have higher acuities, and have more comorbidities than typical patients in short-term acute care hospitals. Grouping long term care hospitals with general hospitals for payment purposes is inappropriate. Long term care hospital patients are exceedingly different than those in general hospitals, and the payment methodology to these hospitals should reflect those differences.

When CMS begins to decide the appropriate site of care for patients, I become concerned that the agency is substituting its judgment for the medical judgment of physicians, who are the individuals that should be solely responsible for determining the best care for their patients.

In addition, the proposed rule goes against fundamental principles of a prospective payment system. By eliminating the opportunity for long term care hospitals to care for patients whose costs of treatment are less than Medicare reimbursement levels, CMS is eliminating any chance for these hospitals to overcome the losses of caring for patients whose costs of treatment exceed reimbursement levels. In essence, CMS is punishing long term care hospitals for providing Medicare patients with efficient care. It is also inaccurate to suggest that long term care hospitals are seeking out more profitable patients when it is impossible to definitively determine which patients are likely to have stays longer or shorter than the average length.

I am further disturbed that this action is not supported by objective, clinical data and is being contemplated before the CMS-contracted study, based on MedPAC's considered recommendations, is completed. The agency's actions are premature and unwarranted. Consequently, I strongly urge you not to implement this rule until this study is complete. These findings could then serve as the basis for a thoughtful, in-depth discussion between CMS, physicians, patients, and the hospitals themselves regarding how to address the agency's concerns in a fair, fiscally sound manner.

I recognize that your work on this issue is vital to the care we provide Medicare beneficiaries and I thank you for your attention to this important matter.

Sincerely,

Yolanda Gonzalez
Director of Marketing
LifeCare Hospitals of South Texas

MAR 17 2006 Form letter 26

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,***

Dear Administrator McClellan:

I am gravely concerned about and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am an Internal Medicine physician who currently works with several long term care hospitals including LifeCare Hospitals of Fort Worth. I have found that these hospitals are a very important part of the healthcare continuum, and I frequently utilize them as a discharge option for my patients.

Sincerely,

MP Adamo DO

Dr. Michael Adamo
1650 West Magnolia, Ste. 207
Fort Worth, Texas 76104

MHA
Massachusetts Hospital Association

March 20, 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS–1485–P
P.O. Box 8012
Baltimore, MD 20244-8011

RE: Proposed Prospective Payment System for Long-Term Care Hospitals, Rate Year 2007

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, submits this letter to comment on the 2007 proposed Long-Term Care Hospital Prospective Payment System. Massachusetts is home to many of the nation's oldest long-term care hospitals (LTCH) that provide some of the most clinically complex post-acute hospital care. Given this large number of providers, we are very concerned with the significant changes being proposed in this rule and the impact it will have on our ability to adequately care for our most vulnerable patient populations. Of significant concern are the proposals to provide no inflationary updates and changing the short-stay outlier (SSO) policy. The alarming net impact of these and other proposals will result in a negative 13.8 percent reduction in Medicare payments for LTCHs in Rate Year 2007. We believe viable alternatives are available for CMS to consider that will provide the needed cost savings to the Medicare program, while assuring that the clinical determination of appropriate level of care continue to be based on medical necessity determination. We recommend several of these viable alternatives to you.

Proposed Changes to LTCH PPS Payment Rates for the 2007 LTCH Rate Year

1) No Inflationary Updates for Rate year 2007:

The proposal to eliminate any inflationary update for RY 2007 is inappropriate and does not take into consideration the growing costs of providing care. CMS's own market basket estimates a 3.6 percent inflation increase for FY 2007, but expenses for LTC hospitals in Massachusetts will most likely increase at nearly twice that rate due to increasing labor costs arising from workforce shortages and other market factors like energy costs. CMS's reasoning articulated in the preamble of the proposed rule is inaccurate for several reasons:

First, CMS inappropriately uses FY 2003 LTCH claims data from the first year of implementation of LTCH PPS compared to the FY 2001 claims data generated prior to the implementation of LTCH PPS to determine an "appropriate" case mix index. Based on this analysis, CMS assumed that the realized increase in case mix index of 6.7 between RY 2003 and RY 2004 is largely due to improvements in LTCH documentation and coding. As MHA and others have commented on in previous rate year comment letters, it is inappropriate to rebase payment rates until the PPS rule has been fully implemented as there are still several hospitals that have not fully phased into the PPS system during the year in question. Second, CMS does not address the fact that there have been several coding corrections made due to the re-weighting the LTCH-DRG weights in RY 2004 and the corresponding reduction in the LTCH-DRG weights during the RY 2006 IPPS rule. Since CMS has already addressed any

potential differences in reimbursement by these changes, there is no basis for providing further corresponding changes in the payment rate by removing the FY 2007 inflationary updates as well. By eliminating the market basket update in RY 2007, CMS will be duplicating reductions that were previously applied in the RY 2006 IPPS rule. As a result, LTCHs will be unfairly penalized twice for the same issue. Finally, there is no recognition in this rule of the efforts made by the American Hospital Association in developing their coding clinic to ensure appropriate coding practices in compliance with the CMS rules.

MHA recommends that CMS provide for the full Market Basket update, until it is able to address these inherent discrepancies. As stated in the preamble to the rule, CMS does not have sufficient data of hospital costs during the applicable PPS period to make such a significant change. Further, significant changes to the LTCH-DRG weights have eliminated the alleged payment increases that must and should be addressed. Further, if CMS believes that additional coding practices are needed, then we encourage CMS to work with AHA in developing more stringent coding practices as currently considered by the Coding Clinic.

2) Changes to the Payments for SSO and QIO Reviews:

MHA is strongly opposed to the two CMS proposals of changing the SSO payment methodology by reducing the current payment formula that is based on costs from 120 percent to 100 percent of the DRG average, and by adding a new requirement that payment would also be the lesser of the three current requirements or the payment for the same type of care under the IPPS rule. The stated goal of creating consistency between the IPPS and the LTCH PPS rule for similar types of services is misguided for the reasons set forth below.

First, this proposal results in significant underpayment to an LTCH based on a payment system that does not properly account for the true costs of LTCH care. Patients with medically complex needs receive an entirely different set of services and care in an LTCH setting than they do in an IPPS hospital. CMS incorrectly states in the RY 2007 preamble that by treating SSO cases, LTCHs may be "functioning like an acute care hospital." However, when the LTCH PPS was introduced in 2003, the agency stated in the Federal Register that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the IPPS system. CMS further noted that paying LTCHs under the IPPS could result in the systematic underpayment of LTCHs. Based on these comments, we strongly feel that the RY 2007 proposed rule unfairly penalizes an LTCH by basing their payments upon a payment methodology that was not intended for or developed using LTCH costs and services. Second, this proposal inappropriately uses payment criteria to define appropriate clinical determination of hospital level of care. Physicians determine admission criteria based on specific clinical screening criteria. Further, these determinations are evaluated by CMS's own contractors (the Quality Improvement Organizations – QIO) to ensure that patient's accessing such specialized services and programs of care may not otherwise be able to receive them in other alternative sites of care. Third, it is not appropriate to create a general policy that all SSO cases in an LTCH should be paid at the same rate as the IPPS. The IPPS rates, even when adjusted for outliers, are not designed nor intended for the high-complexity, long-stay population treated in LTCHs. As such, the RY 2007 proposal to include IPPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of patients. In this case, the LTCH and general acute populations are distinctly unique from one another and should not be tied together for payment purposes. Finally, we would like to point out that if the changes are enacted as proposed, this rule does not allow sufficient time for the fiscal

intermediaries to make the necessary changes to their systems to process the payments. We have heard from several intermediaries in Massachusetts and elsewhere that have indicated that these changes could not be made by July 1, 2006, which will result in substantial payment delays to providers.

MHA recommends that CMS consider a more balanced approach to ensure that patients are treated and cared for in the most appropriate setting. As the SSO cases are diverse in medical need and length of stay, CMS can develop a variety of ways to properly identify and manage the payment for SSO cases to ensure that case are reviewed and paid for appropriately using the following proposals:

1. CMS should support and implement the MedPAC June 2004 and March 2006 recommendations to develop specific LTCH criteria that would expand the current facility qualification to target and certify that the LTCH is treating medically-complex, long-stay patients. The pending recommendations from the Research Triangle Institute International (RTI) are highly anticipated and should be thoroughly examined by CMS and the LTCH field. Many of our hospitals have participated in this review and we are committed to working with CMS to use the RTI findings and develop sound and reasonable criteria to ensure that LTCH services are targeted to patients who are clinically appropriate for that setting.
2. CMS should immediately implement the June 2004 MedPAC recommendation to require the QIOs to review long-term care hospital admissions for medical necessity and monitor LTCH compliance with the expanded qualification criteria. Although CMS has declined to include the review of LTCH cases within the QIO scope of work, in 2004 the agency reinstituted QIO review of a small national sample of approximately 1,400 cases, which resulted in the denial of 29 percent of the reviewed cases. We believe this effort demonstrates that the QIOs are currently equipped and able to perform this function in a manner that preserves access for patients who need LTCH-level care while identifying and denying payment for cases that should be treated in another setting. Expanding the sample size to a larger group of providers would be an effective and immediate proposal for ensuring that LTCHs are serving appropriate patients.
3. Develop a new payment method for very short SSO cases, those that CMS determines are not appropriate for an LTCH setting. This would be a two step process:
    a. To ensure reasonableness and fairness, we propose that CMS create a new definition of a "very short stay outlier case" as those whose length of stay falls far below a certain percentage of the 5/6th geometric mean length of stay for the applicable DRG. We recommend that CMS use a percentage set at 20%. So for example, if the DRG ALOS was 30, then an LTCH who discharged the patient within six days would be paid at a new lower payment rate. Using the same hypothetical, all other discharges that occurred from days 6 to 25 would be paid at the current "lesser of" payment methodology.
    b. For those cases that are discharged within the first six days, using the hypothetical above, the LTCH should be reimbursed at either 100% of the LTCH DRG cost or at a lower rate (a lower percentage of the LTCH DRG – corresponding to 80-90% of the LTCH-DRG in a manner similar to cost outliers now). CMS should base payments on the LTCH PPS rates and not the IPPS rates, to ensure that services are being paid based on the DRG weights attributable to the specific provider type.
    c. In developing this proposal, we would like to note that any proposal for very short SSO cases should allow for appropriate exceptions for cases that are not within the control of the LTCH. Specifically, we would include cases where the patient died within the very short SSO or when the patient exhausted benefits within that very

short SSO time frame. These types of cases in particular are not suitable for inclusion with the rest of the cases given the nature of the patient's condition or prior length of stay in other facilities.

Other Proposed Policy Changes for RY 2007 LTCH PPS Rule

1) The 3 Day or Less Interruption of Stay – Elimination of the Surgical DRG Exception to the Interrupted Stay Policy

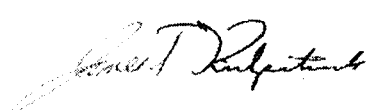
MHA is strongly opposed to the proposal that eliminates the surgical DRG exception from the "under arrangements" proposal adopted in the RY 2006 LTCH PPS rule. This proposal essentially provided that the LTCH is responsible for compensating other providers for surgical care rendered to the patient during the three day interruption of care (e.g., the patient is sent to an Acute care hospital for surgical services during the three day interruption of the LTCH care). MHA strongly believes that the cost of these surgical cases should not be incurred by LTCHs given the fact that these surgical cases are neither included nor factored into the LTCH-PPS base.

MHA would like to point out that any allegations of incorrect coding related to surgical DRG cases should be corrected through the idea expressed above, which is to require greater participation by LTCH and others in the AHA Coding Clinic that has been endorsed by CMS. The allegation that LTCH claims may be incorrect because some LTCH claims included surgical care and are grouped to surgical DRGs is a concern that should be dealt with through better coding practices by working with both the QIO and/or the FI. We continue to believe that without first including these costs in the base and weights for LTCH DRGs, then CMS is inappropriately requiring LTCHs to care for our most vulnerable populations without the ability to receive adequate reimbursement for those services. Several coding errors that have been identified in prior years have been corrected over time.

MHA Recommends that CMS either update the LTCH DRGs to account for these costs or reconsider its decision to immediately eliminate this exception until such costs can be accounted in the DRG weights. It is unfair for CMS to apply a 0% inflationary update, significant changes and cuts to SSO cases, and expect them to continue to shoulder higher unreimbursed costs without changes to the LTCH-DRG weights.

MHA strongly believes that there should be no major policy changes until CMS has reviewed and addressed the inconsistencies and issues outlined in our letter. CMS also should consider the proposals that we have outlined above to ensure that our severely ill and medically complex Medicare patients have access to specialized services and programs of care that may not otherwise be available in other alternative settings. If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 272-8000, ext. 173.

Sincerely,



James T. Kirkpatrick
Vice President, Health Care Finance and Managed Care

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Cornerstone
HEALTHCARE GROUP

March 16, 2006

Via Overnight Delivery
Hon. Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule, 71 Fed. Reg. 4648 (January 27, 2006)***

Dear Dr. McClellan:

This letter presents comments and recommendations by Cornerstone Healthcare Group ("Cornerstone") to certain aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals ("LTCH PPS") for fiscal year 2007, which were published by the Centers for Medicare & Medicaid Services ("CMS") on January 27, 2006 (the "Proposed Rule").

Cornerstone owns or manages eighteen long-term care hospitals ("LTCHs") in eight states and is a member of the Acute Long Term Hospital Association ("ALTHA"). Cornerstone endorses the comments and recommendations submitted by ALTHA with respect to the Proposed Rule. The comments in this letter are intended to supplement ALTHA's and are largely focused on CMS's proposed payment cuts for short stay outlier ("SSO") patients (the "SSO Payment Cut").

The SSO Payment Cut is based on the mistaken assumptions that short stay outlier patients can be identified at the time of admission and that such patients are clinically inappropriate for admission to an LTCH. As explained in detail in ALTHA's comments, Medicare data and the results of reviews by Quality Improvement Organizations overwhelmingly contradict these assumptions. In fact, the data show that SSO patients are largely indistinguishable from other LTCH patients in terms of their diagnoses and severity of illness and are therefore clinically appropriate for admission into the LTCH setting. Because these patients are clinically appropriate for admission into LTCHs, and providers cannot predict their length of stay in advance, there is no policy justification for the SSO Payment Cut. This is particularly the case when the cut is so large in magnitude and will be imposed so quickly that it runs the risk of destabilizing many LTCH providers.

I. Cornerstone uses objective admission criteria to ensure that it admits patients are clinically appropriate for LTCH care.

As set forth in the ALTHA comments, CMS based its decision to impose the SSO Payment Cut in part on the results of a single review by a Quality Improvement Organization, or QIO, on the admissions at a single LTCH. In doing

so, CMS failed to consider other QIO reviews of hundreds of LTCH admissions that overwhelmingly support the proposition that the patients admitted to LTCHs are clinically appropriate for treatment in that setting.

Cornerstone's experience with the QIO review process has been similar to that of the providers cited in the ALTHA comments. From 2004 to 2005, the QIOs reviewed 174 patient records at Cornerstone hospitals. Of this number the QIO only recommended that claims for 3 patients be denied based on medical necessity. An administrative law judge overturned one of these proposed denials and another was for only the last day of the patient's stay at the hospital. Even if one considers the denial of a single day to be a complete denial of the claim, two denials out of 174 is a denial rate of only 1.1%.

The use of objective admission criteria and the existing QIO review process already provide safeguards against inappropriate admissions to LTCHs. Rather than using the blunt instrument of payment cuts to try to affect admission decisions, CMS should adopt uniform admission and continuing stay screening criteria to ensure that all patients admitted to LTCHs are clinically appropriate for such a setting.

II. Contrary to CMS's admitted goal of developing Pay for Performance criteria, the SSO Payment Cut punishes providers that work efficiently to achieve good clinical outcomes for their patients.

CMS has proposed the SSO Payment Cut in response to what it perceives as the inappropriate growth of LTCHs across the nation. CMS is particularly concerned that SSO patients who were clinically inappropriate for admission into an LTCH have fueled a large part of this growth. To address its concern regarding SSO patients, CMS proposes to cap the reimbursement rate for most SSO patients at a rate comparable to what would have been paid to a short term hospital had the patient been admitted to that setting instead. A simple example shows why CMS's proposed policy is fundamentally unsound. The payment rate for LTCHs for a patient who is ventilator dependent assumes that the patient will stay in the LTCH about 34 days, on average. An LTCH could provide excellent care and discharge such a patient after only 26 days. Under the Proposed Rule, the LTCH would receive a payment comparable to the short term hospital payment rate for such a patient, which assumes the patient was only hospitalized for about 8 days. This proposal would result in payments far below the cost the LTCH actually incurred in treating the patient.

The SSO Payment Cut would punish efficient providers of quality healthcare by paying them far below their costs. This is directly contrary to the Pay for Performance model, which should build in incentives for providers to efficiently achieve good clinical outcomes for their patients. CMS has repeatedly endorsed the Pay for Performance concept and has begun several quality initiatives intended to lay the groundwork for incorporating Pay for Performance into Medicare payment methodologies. The SSO Payment Cut is a step backward and actually provides a disincentive for LTCHs to be efficient in delivering quality care to their patients.

III. The Proposed Rule goes too far too fast and could have serious repercussions for LTCH providers.

CMS has estimated that the SSO Payment Cut would reduce payments to LTCHs by approximately 11%. Combined with the proposal to deny the basic inflationary update to cover the rising costs of care, which CMS estimates to be 3.6%, and other recent changes to LTCH coding and LTC-DRG weighting, the overall impact of the Proposed Rule would result in an approximate 15% payment cut for LTCHs. The draconian nature of these cuts is exacerbated by the fact that the cuts would be imposed less than six months after originally being proposed. Because LTCH providers cannot predict which patients will become SSO patients, providers cannot (as CMS assumes) mitigate the effects of these cuts simply by changing their admission criteria. Accordingly, regardless of the time between proposal date and implementation date, the SSO Payment Cut would result in payments that do not cover LTCHs' costs of providing care to a large number of their patients. Simply delaying he implementation date or phasing in the SSO Payment Cut will not alter the fact that it is a fundamentally unsound policy.

By comparison, the implementation of the prospective payment system for skilled nursing facilities ("SNFs") resulted in an approximate 10% payment cut for SNF providers. The SNF prospective payment system was mandated by

the Balanced Budget Act of 1997 ("BBA") and was phased in over four years beginning in 1998. Nevertheless, the payment cuts devastated SNF providers and resulted in hundreds of facilities seeking bankruptcy protection. A 15% cut in LTCH reimbursement with less than six months notice has the potential to wreak even worse financial havoc on LTCH providers than the BBA cuts had on SNF providers. Destabilizing the LTCH provider community in this way would do a grave disservice to the critically ill Medicare beneficiaries that LTCHs serve. Ultimately, such drastic cuts threaten beneficiaries' access to quality healthcare in the most appropriate setting.

IV. Existing LTCH certification requirements already provide a disincentive to admit SSO patients.

The current LTCH certification criteria act as a disincentive for LTCHs to admit SSO patients. Even if LTCHs did not uniformly apply screening criteria to limit all admissions to appropriate patients, and even if SSO patients could be identified at the time of admission, the nature of the current certification criteria provides no encouragement to LTCHs to admit SSO patients. This is because the admission of SSO patients lowers an LTCH's average length of stay and puts the LTCH at risk losing its IPPS exclusion status due to a failure to maintain the required average length of stay of greater than 25 days.

V. Recommendations

Cornerstone recommends that CMS consider the following alternatives to address the issues raised in the proposed rule regarding Short Stay Outliers:

Option 1: CMS should adopt requirements for pre-admission, concurrent and post-hoc review of the appropriateness of LTCH admissions.

a. **Require physician certification of the need for LTCH services prior to or concurrent with admission to an LTCH.** This certification should be based on guidelines established by CMS through rulemaking and public comment. CMS requires physician certification for other Medicare providers to balance the goals of protecting the Medicare trust fund against abuse without impeding access to medically necessary services. This approach directly addresses the issues CMS raised in the proposed rule regarding SSOs. Requiring physician certification of medical necessity for LTCH care would address CMS's concerns that LTCHs are admitting SSO patients for financial reasons.

b. **Adopt uniform admission and continuing stay screening criteria to ensure that only appropriate patients are admitted to LTCHs.** Currently, Cornerstone and many other LTCH providers use patient assessment tools, such as InterQual® Long-Term Acute Care Criteria (McKesson Health Solutions), to assess the appropriateness of patients' admissions, their continued stays and ultimate discharges from its facilities. Requiring the use of this or a similar assessment instrument would meet the goal of ensuring that only appropriate patients are admitted to LTCHs.

c. **Expand the sample of LTCH cases reviewed by QIOs for appropriateness of admission and continued stay.** In conjunction with recommendations a. and b. above, expanded QIO review would be the most direct way to address the issues raised in the CMS proposed rule. This is consistent with the recommendation made by MedPAC in their June 2004 report to Congress.

Option 2: CMS Could Implement Targeted Payment Reforms Directed at "Very Short Stay" Cases.

If CMS decides to use payment mechanisms to attempt to address Short Stay Outliers, it should do so using a much more targeted approach than the SSO Payment Cut. In CMS's March 2002 Proposed Rule, CMS articulated the same concern that has formed the basis for its current proposal – namely, the potential that some short-stay patients may not have been appropriate for LTCH admission. At that time, CMS proposed to address this concern with a more tailored

alternate payment policy for very short-stay discharges. In the August 2002 Final Rule, CMS declined to adopt this policy because it concluded that its concerns were adequately addressed in the broader SSO payment policy. Nevertheless, the very short-stay discharge policy presented in the March 2002 Proposed Rule demonstrates that a more thoughtful and targeted approach to address CMS' concerns is possible.

Cornerstone urges CMS to develop a more targeted alternative payment policy that is tailored to meet any legitimate concerns about inappropriate admissions. Any such alternative payment policy must be based on a rigorous and objective analysis of relevant and current data, and must result in payment amounts that bear a relationship with the LTCH's costs of providing care on average for the affected cases. As discussed above, LTCHs cannot predict, in advance, the length of an LTCH patient's stay, nor should they be required to attempt to make such predictions. However, to remove any incentive that CMS believes LTCHs might have to admit patients for a brief LTCH stay, Cornerstone proposes the following alternatives for CMS to pay for "very short stay" cases:

a. **Define "very short stay" cases as those with a length of stay well below the mean for all LTCH cases (e.g., 5-7 days) and reimburse those cases at cost.** The rest of LTCH cases that are between the "very short stay" and the 5/6th geometric mean threshold for their DRG would be defined as "short stay outlier" cases and would be paid under the current "lesser of" payment methodology. Paying at cost for the "very short stay" cases removes any incentive that might arguably exist for LTCHs to admit patients who could be predicted to have very short lengths of stay.

b. **Reimburse "very short stay" cases (as defined above) at a percentage of cost (e.g., 95% of cost) to remove any incentive whatsoever that LTCHs might have for admitting patients who could be predicted to have very short lengths of stay.** This option would be similar to the payment approach for high cost outliers, but without a "stop loss" feature given the difficulty in predicting lengths of stay or clinical outcomes for those patients. All other SSO cases would be paid under the current "lesser of" methodology. However, if this option is selected, CMS should reallocate the 5% "payment penalty" imposed on very short stay cases to payment levels for other SSO patients.

VI. Conclusion

For the foregoing reasons and the reasons stated in ALTHA's comments, Cornerstone respectfully requests that CMS withdraw the Proposed Rule and issue an interim final rule that incorporates the above recommendations and otherwise addresses the shortcomings of the Proposed Rule.

Thank you for your consideration in this matter. Cornerstone looks forward to continuing to work with CMS on the development of appropriate and effective regulations to govern LTCH providers.

Yours truly,

Michael D. Cress
President and Chief Executive Officer

Darrell D. Zurovec
Senior Vice President and General Counsel

DDZ/dd
Cornerstone Cmts-031606

MAR 20 2006

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Robert A. Ortenzio
Chief Executive Officer

March 15, 2006

BY OVERNIGHT MAIL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1485–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: ***Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification, 71 Fed. Reg. 4648 (January 27, 2006)***

Ladies and Gentlemen:

This letter presents additional comments of Select Medical Corporation concerning the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals, which were published by CMS on January 27, 2006. Previously, on March 1, 2006, we furnished comments on the proposed changes to the method for determining the payment amount for short-stay outlier cases. In this letter, we comment on the discussion in the preamble to the January 2006 Proposed Rule pertaining to (1) the special payment provisions for LTCH hospitals within hospitals and LTCH satellites (Section V.B in the preamble) and (2) the RTI report on MedPAC June 2004 LTCH recommendations (Section XI in the preamble).

In those two sections, CMS does not propose specific regulatory changes, but rather discusses its "concerns" that LTCHs are functioning as long-stay units of general acute care hospitals, treating patients who have been inappropriately admitted to LTCHs for financial rather than clinical reasons, and causing Medicare to pay twice for what would essentially be one episode of care. CMS suggests that it may extend the 25% admissions threshold, currently applicable to LTCHs configured as hospitals-within-hospitals ("HIHs"), to freestanding LTCHs. Because CMS's discussion is filled with baseless insinuations of widespread impropriety, rather than any meaningful evidence that these severe regulatory actions are necessary or appropriate to remediate legitimate concerns, we are furnishing these comments, notwithstanding the absence of any proposals for specific regulatory changes in these areas.

As discussed more fully below, CMS's suggestion of unwarranted growth in the number of freestanding LTCHs, which it claims justifies the extension of the 25% admissions threshold to freestanding LTCHs, is unfounded. Additionally, the extension of the 25% admissions threshold to freestanding LTCHs would conflict with clear Congressional intent to recognize LTCHs as a distinct type of provider exempt from the inpatient prospective payment system applicable to general acute care hospitals ("IPPS"). Furthermore, any extension of the 25% admissions threshold by CMS would be an overly-broad and unstudied regulatory response to unsubstantiated concerns; instead, CMS should address any legitimate and demonstrable

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concerns with targeted and thoughtful regulatory action, such as by following the recommendations of MedPAC to develop facility and patient criteria for LTCHs and by adopting clear prohibitions on the common ownership and control of an LTCH and a general acute care hospital.

I. BACKGROUND

Select is a leading operator of LTCHs in the United States. As of January 31, 2006, Select operated 97 LTCHs in 26 states. LTCH patients have specialized needs, and serious and often complex medical conditions, such as respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds and renal failure. These patients generally require longer lengths of stay than patients in a general acute care hospital and benefit from being treated in a long term care hospital that is designed to meet their unique medical needs.

By statute enacted in 1983, Congress determined that hospitals treating patients with an average inpatient length of stay of greater than 25 days and otherwise meeting the Medicare hospital conditions of participation – that is, LTCHs – should be exempt from IPPS. See 42 U.S.C. § 1395ww(d)(1)(B)(iv)(I). CMS itself has endorsed the Congressional purpose in excluding LTCHs from the payment system applicable to general acute care hospitals. As CMS has said, LTCHs "have few short-stay or low-cost cases, and might be systematically underpaid if the [IPPS] method applied. Thus, exclusion of entire long-term care hospitals from [IPPS] is appropriate." 59 Fed. Reg. 45389 (September 1, 1994).

Congress' directives to recognize LTCHs as a distinct category of hospital provider has continued in place, and was effectively ratified in 1999 and 2000, when Congress mandated the development of a prospective payment system specifically applicable to LTCHs ("LTCH PPS"). LTCH PPS was implemented by CMS in 2002. On August 20, 2002, in accordance with Congress' directive, CMS published a final rule providing for the payment of a fixed amount for an LTCH case based on the diagnosis related group to which the patient is assigned.

In 1994, CMS expressed concern that some purported LTCHs may be effectively "part of" a general acute care hospital and therefore should not be recognized as exempt from IPPS. Specifically, CMS concluded that a general acute care hospital that operates an LTCH on its campus may be able to shift its long-stay patients to the LTCH, retaining only short-stay patients, and thereby profit inappropriately from IPPS. Further, CMS maintained that, unlike rehabilitation units and certain other units, Congress did not intend to permit IPPS-exempt LTCH units of general acute care hospitals. Thus, CMS developed a set of criteria to ensure that an LTCH located on the campus of a general acute care hospital (a "hospital within hospital" or "HIH") would be sufficiently distinct from the "host" hospital, rather than "a 'paper entity' for which the underlying reasons for exclusion do not apply". 59 Fed. Reg. 45391 (September 1, 1994).

In June 2004, the Medicare Payment Assessment Commission ("MedPAC") issued a report to Congress recommending the development of a new, clearer definition of LTCH care. Although MedPAC presented no data of pervasive problems, MedPAC speculated that the combination of general acute care hospitals' payment incentives and the separate payment system for LTCHs could encourage general acute care hospitals to prematurely discharge high-cost patients and LTCHs to admit patients inappropriate for LTCH care. To ensure that patients admitted to LTCHs are indeed those for whom this care is most appropriate, MedPAC recommended that LTCHs "be defined by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement." "Report to the Congress: New Approaches in Medicare," June 2004. In September 2004, CMS

engaged Research Triangle Institute, International ("RTI") to study the feasibility of MedPAC's recommendations. As discussed in the January 2006 Proposed Rule, while RTI has been collecting data for this study, RTI has not completed its work, and its final report is not expected until late Spring 2006. See 71 Fed. Reg. 4726.

In May 2004, CMS proposed new payment policies applicable to LTCH HIHs, which CMS then adopted in August 2004. Motivated by a supposed "proliferation" of LTCH HIHs, CMS asserted that the HIH separateness criteria were insufficient to address CMS's concerns. Based on "anecdotal information", CMS asserted that entities have used "complex arrangements among corporate affiliates, and obtained services from those affiliates, thereby impairing or diluting the separateness of the corporate entity" even though those arrangements "technically [remain] within the parameters" of the separateness criteria. 69 Fed. Reg. 49193. CMS asserted that these complex arrangements include the common ownership of host hospitals and LTCHs, which would enable "payments generated from care delivered at both settings [to] affect their mutual interests." 69 Fed. Reg. 49193. Going further, but citing no evidence to support the validity of CMS's concerns, CMS broadly claimed that host hospitals may be prematurely discharging patients to LTCH HIHs because they are incentivized to do so under IPPS, such that both the host and the LTCH HIH receive separate payments for what might be a single episode of care. Although citing no evidence – or even any effort to study the issue – CMS thus implied that LTCH HIHs are providing services to patients inappropriate for LTCH admission.

On July 9, 2004, MedPAC submitted comments to CMS concerning CMS's then-proposed 25% admissions threshold for HIHs. MedPAC did not endorse CMS's proposal, but rather expressed concerns about it and suggested the need for more empirical evidence and analysis prior to the development of appropriate policy. Specifically, among other things, MedPAC noted that the 25% admissions threshold would do nothing to "ensure that patients go to the most appropriate post-acute setting". MedPAC also noted that it has declined to recommend a moratorium on new LTCH HIHs in response to growth in the number of these facilities since, MedPAC believed, further analysis of the risks posed by LTCH HIHs should take place first. Similarly, MedPAC declined to endorse the 25% admissions threshold for HIHs, noting the need for more evidence of the unique risk posed by these facilities.

In finalizing the 25% admissions threshold for HIH's in August 2004, CMS off-handedly dismissed MedPAC's comment letter and ignored the suggestions contained in MedPAC's June 2004 report to Congress. Despite CMS's stated concerns about the use of complex corporate arrangements, CMS did not preclude the use of complex common ownership arrangements to circumvent the separateness criteria. Nor did CMS pause to validate its assumptions that LTCH HIH are being paid for the same course of treatment provided at a general acute care hospital. CMS did not even seek to develop principles that would adjust payments to LTCH HIHs in those cases where an LTCH patient could be shown to have been inappropriately admitted and effectively continuing to receive general acute care hospital care in an LTCH. Further, CMS did not wait for the results of the RTI study to determine whether its concerns could be addressed through facility and patient criteria to define LTCH care. Rather, in effect, CMS sweepingly assumed that a large number of patients admitted to LTCH HIHs from host hospitals are inappropriate for LTCH care, and implemented payment adjustments that significantly reduce payments to LTCH HIHs to the extent that the LTCH HIH receives more than 25% of its admissions from the host hospital.

Now, in the January 2006 Proposed Rule, CMS implies that it may actually expand the application of 25% admissions threshold to freestanding LTCHs. In its discussion, CMS suggests that, as a result of the imposition of the 25% admissions threshold for LTCH HIHs, there has been unwarranted growth in the number of freestanding LTCHs. Further, CMS claims

that, "based on inquiries from LTCHs and their attorneys or agents" and from fiscal intermediaries, some host hospitals within the same community are arranging to cross-refer to another's co-located LTCH HIH. Again, without any meaningful supportive data, CMS also expresses with respect to freestanding LTCHs the very same concerns that it has claimed to have with respect to LTCH HIHs – namely that LTCHs are functioning as long-stay units of general acute care hospitals, treating patients who have been inappropriately admitted to LTCHs for financial rather than clinical reasons, and causing Medicare to pay twice for what would essentially be one episode of care.

Rather than recognizing that industry inquiries about implementation of the HIH admissions threshold demonstrate that CMS's August 2004 approach is ill-crafted to address concerns about premature discharges and inappropriate admissions, and despite no real evidence of the pervasiveness of any such arrangements, CMS now impugns the necessity and appropriateness of a significant portion of the care provided by freestanding LTCHs. In particular, CMS hints that it may extend the 25% admissions threshold to freestanding LTCHs.

II. DISCUSSION

A. CMS's suggestions of unwarranted growth in the number of freestanding LTCHs is unjustified

As justification for the threatened extension of the 25% admissions threshold to freestanding LTCHs, CMS implies that unwarranted growth in the number of freestanding LTCHs has and will take place. Specifically, CMS states that, in response to the implementation of the 25% admissions threshold for LTCH HIHs, "we have become aware that the growth in the LTCH universe is now occurring through the development of free-standing LTCHs." 71 Fed. Reg. 4698. The facts simply do not support CMS's premise.

Table 1 below sets forth the gross number of new LTCHs and new LTCH beds created during each of the last four calendar years. These statistics show that the rate of growth of new LTCHs and LTCH beds decreased significantly in 2005. In particular, the 22 new LTCHs certified in 2005 represent only 5.85% of the 376 LTCHs that existed as of October 2005.

Table 1: Annual Growth in New LTCHs and LTCH Beds

	New LTCH Provider Numbers					New Certified LTCH Beds				
		Freestanding		HIH			Freestanding		HIH	
Year	Total	Number	%	Number	%	Total	Number	%	Number	%
2005	22	10	45%	12	55%	995	580	58%	415	42%
2004	37	11	30%	26	70%	1,395	541	39%	854	61%
2003	36	11	31%	25	69%	1,547	702	45%	845	55%
2002	25	7	28%	18	72%	966	415	43%	551	57%
Total	120	39	33%	81	68%	4,903	2,238	46%	2,665	54%

Source: CMS Provider of Services (POS) File – 2005 Q4

In fact, even these statistics overstate the growth rate of LTCHs during each of the years presented. First, these statistics represent the number of new LTCHs on a gross basis, rather than a net basis. During 2004 and 2005, Select is aware that at least four LTCHs were closed, of which two were Select LTCHs that closed in 2005. Thus, the number of net additional LTCHs was less that the numbers reflected in Table 1. Second, at least four (and possibly five) of the new LTCHs certified in 2005 were converted from inpatient rehabilitation facilities. We do not believe that these converted IRF facilities reflect a real increase in available health care services or Medicare costs. In particular, Select has previously expressed concern that some LTCHs are being converted from IRFs due to the limitations imposed on IRFs by the so-called 75% rule, and that these converted facilities may not actually be treating the types of medically complex patients appropriate for LTCH. Further, since these facilities previously would have been paid by Medicare as IPPS-exempt IRFs, the conversion of these IRFs to LTCHs will not result in the increases in Medicare payment that the growth statistics might otherwise imply.

Moreover, the future rate of growth of LTCHs can be expected to be even less than the rate of growth experienced in 2005. In particular, the implementation of the 25% admissions threshold for LTCH HIHs can be expected to decrease materially the number of new LTCHs on a gross and net basis. The 25% admissions threshold for LTCH HIHs did not significantly impact the LTCH rate of growth in 2005 because LTCH development projects that were completed in 2005 were too advanced to terminate in response to that regulatory change. The first year during which the 25% admissions threshold for LTCH HIHs is likely to impact the LTCH growth statistics is 2006. During 2006, Select expects that, compared with 2005, it will close more existing LTCHs and open fewer new LTCHs as a result of the 25% admissions threshold for LTCH HIHs.

B. Extending the 25% admissions threshold to freestanding LTCHs would contravene clear Congressional intent to recognize LTCHs as distinct category of hospital provider.

By threatening to impose the same types of payment adjustments adopted with respect to LTCH HIHs upon freestanding LTCHs that receive a significant portion of their admissions from a single general acute care hospital, CMS would be adding yet again to the ranks of LTCH cases that are paid under the IPPS methodology and, in doing so, would be violating the clear will of Congress in establishing LTCHs as a distinct, IPPS-exempt hospital provider type.

As noted above, Congress elected to define LTCHs as a separate hospital type in 1983, and ratified this decision in 1999 and 2000 with the mandate to establish LTCH-PPS, out of concern that IPPS methodologies would be inadequate to compensate these providers for the costs incurred in caring for long-stay patients. Notwithstanding this plain legislative direction, CMS proceeded in August 2004 to impose the IPPS payment formula on LTCH HIH cases referred from the host hospital in excess of the 25% admissions threshold. In the January 2006 Proposed Rule, CMS departed further from Congressional intent by formally proposing to modify its reimbursement policy for short-stay outlier ("SSO") cases so that IPPS principles would govern payment of most, if not all, of these cases. Finally, as part of the same proposal, the agency is threatening to add certain freestanding LTCH patients to the class of long-stay patients whose care would be reimbursed under an IPPS payment methodology. These policy changes – individually and, most strikingly, in their cumulative effect – directly undermine the statutorily-mandated recognition of LTCHs as a distinct hospital provider type.

Further, CMS will not avoid the fundamental conflict between its contemplated proposal and the statutory LTCH definition by characterizing any payment adjustments to freestanding LTCHs as being "comparable" to amounts paid under IPPS. Use of the construct "comparable

to" does not negate the actual effect of the action being considered – namely, to reimburse certain freestanding LTCH cases at rates developed for IPPS-reimbursed general acute care hospitals. CMS says as much itself when it justifies this policy on the view that freestanding LTCHs may be functioning as outgrowths of their general acute care hospitals from which they receive a high percentage of referrals, despite the absence of any evidence that such LTCHs are failing to meet the 25-day statutory certification standard. Using "comparable to" language, as CMS has with respect to the HIH and proposed SSO payment adjustments, does not change the fact that, contrary to Congressional mandate, LTCHs will be paid as IPPS-reimbursed general acute care hospital for a significant number of their cases.

Importantly, as long as a hospital meets the statutory standard for LTCH certification – demonstrating an average Medicare length of stay of greater than 25 days – Congress has required that the facility be paid as an LTCH, not a general acute care hospital. Absent a shift in Congress's long-stated and unchanged position concerning the distinct status of LTCHs, CMS lacks the authority to adopt a payment methodology for LTCH cases that equates them with cases treated by an IPPS-reimbursed facility.

C. CMS's stated concerns are resolved more effectively by adoption of MedPAC and industry recommendations to better define LTCH level of care and by adoption of clear prohibition on common ownership and control of an LTCH and general acute care hospital

1. CMS asserts without basis that LTCHs are engaged in improper business practices

CMS's discussion is filled with baseless insinuations of widespread impropriety, including accusations of implementing business practices to "circumvent" regulatory requirements. Select conducts its business in compliance with all regulatory requirements and is not engaged in improper conduct, and we challenge CMS's allegations of pervasive improper business conduct by the LTCH industry.

For example, CMS reiterates its perspective that "entities have used complex arrangements among corporate affiliates" to maintain mere technical compliance with HIH separateness requirements. 71 Fed. Reg. 4696. Select is not a participant in any such "complex arrangements"; its LTCH HIHs are owned and operated by independent entities rather than corporate affiliates of their host hospitals. In fact, Select has consistently advocated revision to the HIH separateness criteria to close any loophole for LTCH HIHs that are under common ownership with a general acute care hospital.

In addition, CMS claims that it is "anecdotally aware of the existence of frequent 'arrangements' in many communities between Medicare acute and post-acute hospital-level providers that may not have any ties of ownership or governance relating to patient shifting that are based on mutual financial advantage rather than on significant medical benefits for a patient." 71 Fed. Reg. 4697. Select is unaware of – and certainly not a participant in – any arrangement by which referrals are made, or patients accepted, based on considerations other than the medical necessity and appropriateness of LTCH care for each patient. CMS's accusations concerning the pervasiveness of improper arrangements appear to be uninformed and overstated.

CMS also claims that the 25% admissions threshold for HIHs is being circumvented by "creative patient-shifting" in some communities where there is more than one LTCH HIH. CMS cites "inquiries from LTCHs and their attorneys or agents, and also from questions posed by our fiscal intermediaries" as evidence of this activity. 71 Fed. Reg. 4696. Select is not a participant

in, and is not aware of, any cross-referral arrangements designed to circumvent the 25% admissions threshold for HIHs. Furthermore, inquiries to CMS and its agents concerning how CMS is applying the 25% admissions threshold for HIHs is weak evidence – if it is evidence at all – that such arrangements are taking place and, if they are, that the proper regulatory response is extension of the 25% admissions threshold.

CMS then notes that, since the adoption of the 25% admissions threshold for HIHs, most new LTCHs have been freestanding rather than HIHs, and that "at least one particular LTCH chain that formerly specialized in the establishment of [LTCH HIHs] is now concentrating on the development of free-standing LTCHs." On this basis, CMS then accuses the LTCH industry of "circumventing the intent" of the 25% admissions threshold for HIHs. 71 Fed. Reg. 4698. This outrageous suggestion of impropriety reveals the arbitrary and capricious manner in which CMS is developing payment policies for LTCHs. Nowhere has CMS pointed to any evidence that freestanding LTCHs developed following the 25% admissions threshold for HIHs are admitting patients inappropriately. Nor can CMS possibly support the assertion that adaptation of a provider's business plans in response to regulatory changes is, by definition, a "circumvention" of regulatory intent.

2. CMS improperly assumes that freestanding LTCHs are furnishing inappropriate care

In the January 2006 Proposed Rule, CMS asserts its concern that Medicare may be paying twice for what would essentially be one episode of care – once to the general acute care hospital and once to an LTCH. This is essentially the same concern that CMS expressed with respect to patients admitted to LTCH HIHs from host hospitals. CMS implies that this concern warrants the extension of the 25% admission threshold to limit freestanding LTCH admissions from any single general acute care hospital. This would result in a significant decrease in payment to LTCHs for the care that they furnish to patients based solely on the source of the referral of the patients. The extension of the 25% admissions threshold, like the 25% admissions threshold applicable to LTCH HIHs, is therefore necessarily based on the unsubstantiated and false assumption that a large number of LTCH patients admitted from general acute care hospitals are inappropriate for LTCH care.

In fact, CMS has cited no meaningful evidence that LTCHs are furnishing care to patients who are inappropriate for LTCH care. As we discussed in our March 1, 2006 comment letter, Select's LTCHs apply the InterQual® Long-Term Acute Care Criteria (McKesson Health Solutions), in order to assure the appropriateness of LTCH admissions. Our March 1, 2006 comment letter provided statistics showing that, in fact, by applying this criteria, Select refuses admission of about half of all referrals whose appropriateness for LTCH care cannot be demonstrated.

Furthermore, in our March 1, 2006 comment letter, we noted that Select's experience with retrospective review of our LTCH patients by QIOs supports the conclusion that the patients admitted to Select's LTCHs have been appropriate for LTCH care. We provided statistics showing that less than 1 percent of Select's LTCH admissions were found to lack medical necessity. Thus, QIO review of Select LTCH cases further refutes CMS's assumption that LTCH patients are overwhelmingly inappropriate for LTCH admission.

By suggesting that the 25% admissions threshold should be extended to freestanding LTCHs, CMS assumes that the appropriateness of a patient's admission to an LTCH bears some relationship to the source of the referral. CMS has presented no data to show any connection between the source of the referral and the appropriateness for LTCH admission. The assumption

of such a connection is unprecedented – CMS does not assume the impropriety of physician referrals to general acute care hospitals based on the volume of those referrals, or the impropriety of general acute care hospital referrals to home health agencies based on the volume of referrals, for example.

Like the 25% admissions threshold for HIHs, the extension of the 25% admissions threshold to all LTCHs would inequitably burden patients of academic medical centers and tertiary care hospitals. These types of general acute care hospitals tend be larger and to serve a more medically-complex patient population, and therefore would be more likely to have a greater number of patients appropriate for LTCH admission. These hospitals may be located in communities where few LTCHs operate. The effect of the extension of the 25% admissions threshold would be that patients of these hospitals would not have access to LTCH care for reasons unrelated to their appropriateness for such care.

3. CMS now threatens to mischaracterize many LTCHs as "units" of general acute care hospitals

In the January 2006 Proposed Rule, CMS states its belief that "the danger of LTCHs functioning as 'units' appears to be occurring not only in LTCH HwHs and LTCH satellites but also with free-standing LTCHs and that in many cases, these non-co-located LTCHs and their sole referral source may be functioning in ways that appear to have erased the line of 'functional separateness' between these LTCHs and their referring acute care hospitals." 71 Fed. Reg. at 4698. Select concurs with CMS that mandating functional separateness between general acute care hospitals and LTCHs, whether they be HIHs or freestanding facilities, is an important foundation of Medicare certification and reimbursement policy in order to maintain the integrity of both the IPPS and LTCH-PPS. This said, however, CMS's allegation that LTCHs are functioning as acute care hospital "units" is misdirected and the threatened response of further payment adjustments fails to resolve the agency's legitimate concerns fully and precisely.

The Medicare program has recognized rules concerning "units" of general acute care hospitals. Under the unit certification principles detailed at 42 C.F.R. § 412.25, these subproviders are required to demonstrate a high level of financial and operational integration with their main provider hospital. For instance, the unit is required to be "part of [the hospital] institution" such that, among other things, the unit and hospital operate under the same Medicare provider agreement, are serviced by the same fiscal intermediary and file a single Medicare cost report. This degree of integration justifies application of the favorable cost allocation policies applied to the hospital and subprovider as a combined provider entity. As a consequence of the symbiotic relationship between a hospital and its unit, it is expected and accepted that the vast majority, if not all, of the unit's patients are referred from the main provider hospital. The unit functions as a direct outgrowth of the hospital, indistinguishable from a corporate, organizational or financial perspective and distinguishable only on the basis of the type of service furnished to patients.

By characterizing LTCHs that receive a significant portion of their patients from a single general acute care hospital as "units," CMS fundamentally misapplies the unit concept as it has been long-understood in the Medicare program. Neither freestanding nor HIH LTCHs – even those that accept more than 25% of their patients from a single general acute care hospital – demonstrate the type of operational and financial integration with a referring hospital that are the hallmarks of "unit" status. Each LTCH operates under a distinct provider agreement with the Medicare program, files cost reports independently from any other provider, and satisfies the Medicare hospital conditions of participation independently from any other provider. Both Select's freestanding LTCHs, by virtue of their independent status, and its LTCH HIHs, as

mandated by the separateness standards in 42 C.F.R. § 412.22(e), uniformly demonstrate high levels of corporate and functional independence from any general acute care hospital. To suggest that such independently-operated provider activities somehow constitute hospital "units," as that term has been historically applied within the Medicare program, is unprincipled and unprecedented.

Thus, absent any other indicia of "unit" status, CMS is relying inappropriately on LTCHs' admissions sources to assert that these providers lack "functional separateness" from general acute care hospitals. CMS simply lacks any legitimate basis to equate a significant referral relationship between different hospital provider types with an inappropriate conflation of provider operations.

4. CMS's threatened regulatory changes undermine the purpose of the RTI study

As described above, in Fall 2004, CMS awarded RTI a contract entitled "Long-Term Care Hospital (LTCH) Payment System Refinement/Evaluation," in response to MedPAC recommendations to define LTCHs by facility and patient criteria in order to ensure that only medically-appropriate patients are admitted to LTCHs. In CMS's own words, the RTI study "will result in a report that will assist CMS in the development of criteria for assuring appropriate and cost-effective use of LTCHs in the Medicare program." 71 Fed. Reg. 4704. The agency acknowledges further that it "expect[s] the final RTI report ... to have a substantial impact on future Medicare policy for LTCHs...." *Id.* at 4726. Given the understood significance of RTI's on-going work, CMS's consideration at this time of further payment adjustments for freestanding LTCHs is, at best, premature, and, at worst, undermines the legitimacy of RTI's efforts.

Many of the positions asserted by CMS throughout its discussion on the possible application of an admissions threshold to freestanding LTCHs – that payments to LTCHs constitute a second payment for a single episode of care and that certain LTCHs function as indistinguishable components of general acute care hospitals – are based upon the implicit premise that the care furnished by LTCHs and general acute care hospitals is essentially equivalent. Not only has CMS failed to cite any data to support these positions, but the premise underlying the agency's unsubstantiated beliefs prematurely assumes the outcome of the RTI study that CMS, itself, commissioned. It was unjustifiable for CMS to finalize the HIH admissions thresholds before the question of how better to define LTCH services had been fully and properly analyzed, but it is now wholly unreasonable for the agency to consider extending this misguided policy to additional LTCH cases before RTI's assessment has been fully reported and evaluated by all stakeholders.

In fact, CMS's threatened application of admissions thresholds to freestanding LTCHs, as well as its comment that payment adjustments may continue to be warranted notwithstanding RTI's findings and recommendations, raises serious questions about the level of objectivity with which the agency will analyze and act upon RTI's final report. Responsibilities to Medicare beneficiaries and to the Medicare program dictates that CMS refrain from proposing and adopting policies that presume a yet-undetermined outcome from RTI's work. Absent this restraint, observers are left to conclude CMS is prejudiced in its view of the issues being evaluated by RTI and that RTI's study is an empty exercise to which CMS can be expected to give little, if any, meaningful weight in future policy-making.

5. CMS should implement more appropriate responses to address any legitimate and documented concerns

CMS not only is misguided in asserting, without the benefit of any study, the existence of systemic improprieties among LTCHs, but also suggests a regulatory response that does not target its articulated concerns. Simply put, the extension of the 25% admissions threshold to freestanding LTCHs, like the 25% admissions threshold for HIHs, would be another misdirected response to an unsubstantiated concern.

Significantly, because extension of the 25% admissions threshold to freestanding LTCHs would results in additional payment cuts based on the source of referral rather than the impropriety of the admission, this regulatory response is both over inclusive and under inclusive. Not only will this approach result in payment cuts for care furnished to patients who are demonstrably appropriate for LTCH care, but also, since CMS's policy is focused on a patient's referral source, it could allow full LTCH payment to unscrupulous LTCHs that accept medically-inappropriate patients.

In the past, CMS has disregarded MedPAC's recommended approach to address any concerns about LTCH care by establishing facility and patient criteria, and MedPAC's cautions about the inequities that result from the 25% admissions threshold for HIHs. Rather than expanding the 25% admissions threshold to freestanding LTCHs, CMS should heed MedPAC's advice by working with the LTCH industry to implement MedPAC's recommendations that facility and patient criteria be developed to ensure that patients admitted to LTCHs are medically complex and have a good chance of improvement. This approach would directly address CMS's worries that some LTCHs may be treating patients who have been inappropriately admitted to LTCHs for financial rather than clinical reasons and causing Medicare to pay twice for what would essentially be one episode of care. Yet, it would prevent a number of inequities and undesirable results, including effectively denying access to LTCH care for appropriate patients based on the source of admission.

Moreover, CMS's concerns about the functional separateness between LTCHs and general acute care hospitals should be addressed by strengthening the restriction on common ownership and control of these two provider types. Only by tightening restrictions on common ownership and control of LTCHs and general acute care hospitals can the Medicare program be assured that corporate affiliates are not benefiting financially from the operation of both general acute care hospital and LTCH providers.

III. CONCLUSION

CMS's suggestion of unwarranted growth in the number of freestanding LTCHs, which it claims justifies the extension of the 25% admissions threshold to freestanding LTCHs, is unfounded. Additionally, the extension of the 25% admissions threshold to freestanding LTCHs would conflict with clear Congressional intent to recognize LTCHs as a distinct type of provider exempt from IPPS. Furthermore, any extension of the 25% admissions threshold by CMS would be an overly-broad and unstudied regulatory response to unsubstantiated concerns. By pursuing the threatened payment adjustments, CMS would be flouting the stated views of MedPAC that implementation of LTCH admissions thresholds does not assure that Medicare beneficiaries receive care in the most appropriate post-acute setting and that such regulatory changes are premature in the absence of further, appropriate data analysis. Instead, CMS should address any legitimate concerns with targeted and thoughtful regulatory action, such as by following the recommendations of MedPAC to develop facility and patient criteria for LTCHs and by adopting

clear prohibitions on the common ownership and control of an LTCH and a general acute care hospital.

We would welcome the opportunity to meet with CMS's representatives to discuss further CMS's concerns and to assist in developing appropriate regulatory responses.

Very truly yours,

Robert A. Ortenzio
Chief Executive Officer

cc: Mr. Tzvi Hefter (by electronic mail)
Ms. Judy Richter (by electronic mail)

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Friday, March 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: Comments on Medicare Program; 2007 Proposed Update Rule
Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

The very existence of New England Sinai Hospital is threatened by the Centers for Medicare and Medicaid Services (CMS) proposed rules seeking to significantly change the admission practices of long term acute care hospitals as well as payment policies.

For approximately 25 years, I have volunteered my services as a Director of the New England Sinai Hospital that includes the past 13 years as Treasurer and Chairman of the Finance Committee.

Although I am not an employee, I do observe the concern of the 500+ employees in their daily efforts to fulfill their mission of quality care and safety to the patients.

The contemplated rule changes for the short-stay patients will compound the yearly challenge of the hospital to address its own monetary obligations and put into jeopardy the actual existence of the New England Sinai Hospital.

If so, then the present staff and the community will suffer severe economic consequences.

Conceivably, these people who are among the 1000+ present and past participants in the Defined Benefit Program will not realize their accrued benefits.

Everyone at NESH has taken great pride in the history of the hospital, its accomplishments and the favorable recognition for its endeavors as a leader in long term care whenever a medical visitation/review has occurred by various government agencies.

The New England Sinai Hospital has carried forth a tradition in service to the poor of Boston and southeastern Massachusetts since it's founding in 1927 as the Jewish Tuberculosis Sanatorium in Rutland. Throughout the hospital's rich history, it has continued to provide healthcare services to this population. Today, operating as a 212-bed hospital in Stoughton, Sinai provides pulmonary care, ventilator care, complex medical care and physical rehabilitation as well as a full array of outpatient services.

A large percentage of Sinai's patients are public payor dependent, with about 70% being Medicare and 15% being Medicaid. CMS' proposed short-stay outlier rule and zero update proposal, would drastically reduce payments to New England Sinai Hospital in fiscal year 2007 by approximately 17 percent, forcing New England Sinai Hospital to operate at a loss when treating Medicare patients. The CMS proposed rule would result in a $5.4M operating loss from Medicare, which cannot be recovered from other payors because of their small numbers.

For almost 80 years, New England Sinai has had an exemplary record in providing care to long-term acute care patients. Over these nearly eight decades Sinai has continually and constantly demonstrated its commitment to this patient population, and it is dedicated to continuing this commitment well into the future. However, the continued operation of New England Sinai Hospital and the patients it serves will be placed in jeopardy if CMS adopts the proposed short-stay outlier rule and zero update proposals. New England Sinai Hospital, with its long-standing history of caring for these patients, and older hospitals like Sinai, should at the very least be grandfathered from implementation of this rule. This would insure that the good work that has been done by these hospitals is not threatened due to the perceived abuses of other newer hospitals. As an officer of New England Sinai Hospital, I urge CMS to not adopt the proposed short-stay outlier rule and zero update proposals.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to LTCHs. CMS' presumption is that SSO cases should have remained in acute hospitals. 71 Fed. Reg. at 4648. The following discussion explains why this presumption is incorrect.

1. Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary SSO patients have a relative case-mix index of 2.0592, which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term acute

hospitals. Therefore, these SSO patients have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments.

The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCHs vs. 4.81%. The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals.[1]

2. CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictably improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO:

[1] This data is obtained from a March 3, 2006 report by The Lewin Group prepared for the National Association of Long Term Hospitals.

- Some SSO cases may achieve medical stability sooner than originally expected;
- Some cases may become SSO and require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH;
- Some patients admitted to LTCHs from acute care hospitals may become SSO cases due to unexpected death;
- Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission;
- Some patients may sign themselves out against medical advice.

3. There is no basis for a proposed rule, which assumes that SSO cases should have remained in acute hospitals. CMS ignores the fact that a significant number of SSO cases are not admitted from acute hospitals, but rather at the direction of a patient's attending physician, are admitted from home or a nursing facility. It is inappropriate for CMS to presume that a patient admitted to an LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

4. CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

5. The proposed SSO rule is an unprecedented intrusion on physician decision-making and contrary to long-standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

6. CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs, composed of licensed doctors of medicine, to determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

The proposed SSO policy conflicts with the principles applied by QIOs to determine whether SSO cases should remain in an acute hospital. QIOs apply professionally developed criteria including screening criteria in making their determinations. See section 1154(a)(1)(B) and 6(A) of the Act and 42 C.F.R. §476.100. They also assess the appropriate medical care available in the community. See 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIOs are required to use national, or where appropriate, regional norms in conducting their review. See Section 1154(a)(6)(A) of the Act and 42 C.F.R. §476.100(a). QIOs also are required to establish written criteria based on typical patterns of practice in the QIO area, or to use national criteria where appropriate. See 42 C.F.R. §476.100(c). CMS' presumption that all SSO cases should remain in acute care hospitals lacks factual support and fails to consider which type of hospital care and programs are in the best interest of Medicare beneficiaries. It irreconcilably conflicts with the statutory and regulatory scheme which delegates to QIOs' the responsibility to establish criteria to operate in the best interest of Medicare beneficiaries.

No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO proposal will force New England Sinai Hospital to operate at a loss. It is unfair and unreasonable to deny LTCHs any inflation allowance particularly since the applicable fiscal year 2007 market basket increase is 3.6%. CMS' proposal places the ongoing operation of New England Sinai Hospital in jeopardy. At a minimum, it will reduce the ability of New England Sinai Hospital to finance medical care and services provided to indigent populations and to defray the cost of bad debts. Ultimately, it will threaten the ability of New England Sinai Hospital to survive.

SCCI Hospital
Specialized Complex Care
335 Glessner Avenue • Mansfield, OH 44903 • 419/526-0777 • Fax 419/526-0929 • www.sccihospitals.com

March 17, 2006

VIA OVERNIGHT DELIVERY

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS 1485P, "Other proposed policy changes for 2007 LTCH PPS Rate Year, Proposed Adjustment for Specific Cases, Adjustments for SSO Cases"

Dear Administrator:

This letter represents certain comments and recommendations from Triumph HealthCare to key aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs) for FY 2007. I have outlined below the fundamental issues which we believe to be severe and arbitrary.

Although there are many policy changes proposed and contemplated in this proposed rule, and I will have additional comments on those in a later letter, this letter will focus entirely on the "Adjustment for SSO Cases and Proposed Changes to the Method for Determining the Payment Amount for SSO Cases." My attention in this letter will focus primarily on the use of Short Term Acute Hospitals (STAC) IPPS system for Short Term Outliers (SSOs) of LTCHs, or as CMS refers to it, a payment system comparable to STAC IPPS.

When Congress originally excluded LTCHs from IPPS in 1983 (and CMS originally issued regulations for LTCHs), they were excluded because of the vastly different types of patients treated and resources consumed. Specifically, CMS stated that this exclusion from IPPS was because the use of IPPS for LTCH "would be inaccurate and unfair" and was "not designed to account for types of treatment" found in LTCHs [Federal Register 67 (August 31, 2002): 55957]. CMS itself in 2002 said that applying IPPS to LTCHs could "systematically underpay" LTCHs "if the same DRG system were applied to them" [Federal Register 67 (August 31, 2002)].

With the proposed rule, CMS is now completely reversing its own position and proposing that LTCHs be paid IPPS rates for 37% of the patients treated in LTCHs (SSOs). Clearly, when 37% of patients are paid a rate of less than 43% of the actual costs to provide care, hospitals will suffer severely, and ultimately so will patients, families, nurses, physicians, and the community

at large. *This proposal will endanger the most vulnerable and fragile patients in our society and likely the industry as a whole.* CMS is proposing to pay LTCH IPPS rates for SSOs based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care provided by LTCHs across the country.

This proposal is based upon numerous erroneous assumptions such as:

1. **LTCHs are taking "premature and inappropriate" patients who have not received their full care from the STAC.**

In fact, admissions to LTCHs from STAC hospitals actually had over double the average length of stay in the STAC hospital than the STAC average for those same DRGs. Specifically, patients admitted to an LTCH from an STAC hospital averaged more than a 13-day stay in the STAC before admission to LTCH vs. the geometric mean of those same DRGs in STAC of six days. Therefore, LTCH patients had twice as long a hospitalization as normal in the STAC to receive their normal amount of care before admission, a direct contrast to the "premature and inappropriate" accusation. In addition, since the issuance of the 2004 Medpar data that was used in this analysis, CMS has added an additional 200 DRGs under the Transfer Regulations that will further discourage STACs from making premature discharges to LTCH. The impact of the additional transfer DRGs was not even considered in this proposed rule. Even though these SSO patients have had an extensive stay in STAC before admission to LTCH they are still severely ill. Under the new AP-DRG system the percentage of severely ill patients in LTCH is double that of the STAC – 66% LTCH versus 33% STAC (% of APDRG Severity of Illness (SOI) categories 3&4).

2. **LTCH SSOs are predictable and hospitals are admitting them because of an "inappropriate financial incentive" and are admitting patients "with lengths of stay more typical of an acute care hospital."**

In fact, average length of stay for SSOs in LTCHs is 13.1 days vs. geometric mean length of stay (GMLOS) in STAC for the same DRGs of 6.1 days. Therefore, the LTCH patients have a length of stay averaging over twice the length of stay in STAC for the same DRG. The patients being admitted to LTCH are not the same and should not be treated the same as the general population of the STAC.

A significant portion of LTCH SSOs are patients that unfortunately, and unexpectedly, die. For Triumph, 24% of our SSOs are attributable to deaths. The faulty assumption has been that LTCHs can predict deaths and are taking these SSOs intentionally. *This could not be further from the truth.* Because of the severity of illness of LTCH patients and the number of co-morbidities, the predictability of length of stay and death is much less accurate than in STAC. In fact, even in STAC there are a large number of early deaths when compared to GMLOS. While clinicians may exercise sound judgment and have "gut feels," there are no accurate tools

available for predicting mortality in an LTCH setting. The need for LTCHs to exceed the 25-day LOS also undercuts the argument that LTCHs intentionally take short stay deaths. LTCHs sometimes unexpectedly have a 25-day problem. Almost always it is because of unexpected deaths.

The patients are severely ill with 66% of SSOs in LTCHs in AP-DRG severity of illness categories (SOIs) of 3 (major) or 4 (extreme) compared to STAC average of 33%. LTCH patients average at least one more co-morbidity than the STAC average and patients are two years older than even the average age of outliers in STACs.

Additionally, more than 10% of Triumph SSOs were already outliers in STAC before admission to LTCH, certainly not early discharges from a STAC facility. More than 7% of SSOs had greater than a 25-day length of stay each, hardly a typical stay at a STAC facility.

3. 37% of patients in SSOs is "inappropriately high."

CMS utilized FY 2004 Medpar data to develop the payment policies included in the proposed rule. Not only does this data reflect just the first year of transition into PPS for LTCHs, a substantial number of LTCHs had not even fully transitioned to PPS in FY 2004. Therefore, with one year of data, CMS concludes that SSOs in LTCHs have dropped from 48.4% to some 37% one-year post transition to PPS. A drop from over 48% to 37% would hardly suggest that the payment policies in place were not having the desired effect. Recent data released by Lewin shows that STACs have 40% of their cases shorter than 5/6 of their GMLOS, so is this inappropriately high? Of course not. It is the nature of the bell curve and the PPS system that some patients fall below and some fall above the mean. A cutoff was chosen (5/6) related to the cost methodology (120% of cost) and the desire not to create a cliff. Then the original percentage was noted (48.4%). Then the drop was noted (37%). Then, finally, a new formula was created (IPPS for SSOs) *based on no identifiable data or appropriate methodology.* Even though the lengths of stay compared to STAC are more than double, the severity of illness in LTCH is also double that of STAC. Many cases are already outliers in STAC before admission to LTCH, many SSOs are unpredictable deaths and a sizable number have more than a 25-day length of stay in LTCH, yet CMS proposes to pay LTCHs via a system developed for a completely different patient population.

Assessment of IPPS for LTCH

This payment methodology also will create a "cliff" (exactly what CMS did *not* want to do) just before the 5/6 point because it is based on STAC IPPS which has a very short GMLOS. The average length of stay in STAC is 5.3 days versus LTCH of over 25 days. The proposed payment methodology would generally pay a full IPPS DRG payment at six days and no additional payment until the 5/6 point or at least 22 days. That is 16 days without additional reimbursement. That the vast majority of these patients do not hit outlier status in LTCHs (81%

of SSOs w ll be paid under proposed IPPS) and the closer they get to the 5/6, the lower the payment pe day is until the difference (between full pay and IPPS pay) the day before the full LTCH DRG i the largest "cliff". This is directly contrary to your own opinion [Federal Register 71 (January 27, 2006): 686] where you state supportively that the cost methodology "which results in a gradual increase in payment as the length of stay increases without producing a payment 'cliff' at any one point, provides a reasonable payment option under the SSO policy." The IPPS methodology when applied to SSOs creates exactly this cliff the longer the patient stays past the GMLOS for STAC and the closer they get to 5/6. We have already established that the average length of stay for SSOs is over double STAC GMLOS. The interaction of the lower of cost or IPPS will result in the perverse financial incentive of maximizing SSO reimbursement at the GMLOS for STAC or around six days. **Given your theory of "inappropriate financial incentives" you should expect average SSO length of stay to be around six days in LTCHs based on this perverse economic incentive.**

The result will be limiting access to care for any type of diagnosis/treatment that might have a long stay but has a substantial portion of that type of patient having a 17-18 day length of stay, such as ventilator (DRG 475). Too many of these SSOs will cause a hospital to go under even though the majority might meet the GMLOS and those who missed only missed by a few days. *The most fragile, older, unpredictable, and vulnerable patients would be the most at risk.* SSO patients are older, sicker, more intense, more unpredictable, more likely to die and thus are the types of patients LTCHs are supposed to admit and care for. However, a significant percentage have the unfortunate problem of unexpected death or other unexpected outcomes.

Even though a cursory analysis of the data would prove the above points, CMS is proposing paying LTCHs on average 43% of costs for SSOs. In fact, the longer the stay, the less the pay per day. The reason we admit them now is not because of our "inappropriate financial incentive" or desire to get "premature and inappropriate" admissions, but because these patients need our specialized care, are no longer appropriate for STAC, and would benefit clinically from our services. Although our SSO patients are sicker and length of stay is twice as long as STAC, we would be paid less per day as the patient gets closer to the LTCH GMLOS.

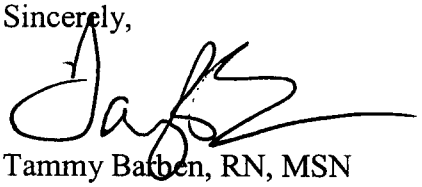
Alternatives and Conclusion

CMS should implement a method as proposed by MEDPAC designed to tighten clinical and facility criteria to address the concerns about clinical appropriateness. Triumph and the industry as a whole are concerned about this as well. We would welcome the chance to work together with CMS on this issue. CMS should release and use the RTI analysis to develop proposals rather than initiating this vast change without this study. If CMS is concerned about very short stays it should use a variation on the original proposed regulation on LTCH PPS which is to have a separate, lower payment for up to seven-day stays. That is, pay a lower percentage of cost for these very short stays as is done for high cost outliers. CMS should use the cost methodology for all SSOs even though we do not find it desirable. It is, however, much better and more

appropriate for SSOs, relates to length of stay, and does not create a cliff as STAC IPPS does. QIOs should be held to their responsibility of enforcing clinical criteria and monitoring LTCHs to ensure appropriateness. We believe the combination of the above alternatives would slow the growth of the industry, meet many of CMS's concerns, and ensure the appropriateness of patients in LTCHs as well.

In closing, CMS should work with the industry, not seek to destroy it.

Sincerely,



Tammy Barben, RN, MSN
Chief Executive Officer

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ORIGINAL

March 16, 2006

VIA OVERNIGHT DELIVERY

MEMORIAL HERMANN

Mark McClellan, M.D. Ph. D
Centers for Medicare & Medicaid Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

Memorial Hermann Hospital System (MHHS) submits these comments on the proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4648 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCH). MHHS is the largest not-for-profit community based health system operating in Houston Texas. It serves a significant percentage of Medicare patients residing in the Greater Houston area (currently over 35,000 discharges annually). The changes being proposed will not only affect the LTCH providers in the Medicare Program but will have a spill over impact on the Acute Care Hospitals. The proposed LTCH short-stay reimbursement changes will only add to the difficulty of moving the chronically ill Medicare patients through the care continuum. This jeopardizes our ability to continue to meet the communities' needs if patients needing LTCH services now have additional regulatory/ reimbursement issues for transfer.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to LTCHs. CMS' presumption is that SSO cases should have remained in acute hospitals. 71 Fed. Reg. at 4688. As discussed below this presumption is wrong.

The Medicare Geometric Length of Stay (GLOS) for our LTCH transferred patients is 7.61 while the actual Length of Stay (LOS) for these patients is 9.98. These patients are with us 2.37 days over the Medicare recommended GLOS before they are transferred. This clearly indicates that this patient population is remaining in the Acute Care side longer under the current criteria. The new proposed (SSO) criteria will force operating LTCHs to change their admission protocols. We foresee this 2.37 LOS gap to only widen under the proposed rules. Under the current policies we currently provide over 2 days of un-reimbursed care for this patient population. These patients represent 8% of our Acute Discharges. To set up a system that would add to the difficult of transferring these patients will only exasperate an already bad situation.

There is no basis for a proposed rule which assum[illegible]s that SSO cases should have remained in acute hospitals. CMS ignores the fact that a sig[illegible]ificant number of SSO cases to LTACs are not admitted from acute hospitals but rather, at [illegible]e direction of a patient's attending physician, are admitted from home or a nursing facility. It is inappropriate for CMS to presume that a patient admitted to an LTCH from a non-acu[illegible] hospital setting, at the direction of the patient's attending physician, who subsequently beco[illegible]es a SSO should not have been admitted to the LTCH in the first place.

CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to preclude these Medicare recipients from admission to an LTCH simply based on the number of their remaining Medicare days.

The proposed SSO rule is an unprecented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to LTCHs based on medical necessity, i.e., the need for specific programs of care and services provided in the LTCH.

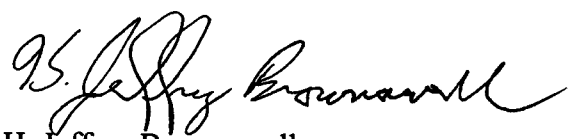
Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries. QIOs, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections 1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

The proposed SSO policy conflicts with the principles applied by QIOs to determine whether SSO cases should remain in an acute hospital. QIOs apply professionally developed criteria including screening criteria in making their determinations. See Section 1154(a)(1)(B) and 6(A) of the Act and 42 C.F.R. §476.100. They also assess the appropriate medical care available in the community. See 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIOs are required to use national, or where appropriate, regional norms in conducting their review. See Section 1154(a)(6)(A) of the Act and 42 C.F.R. §476.100(a). QIOs also are required to establish written criteria based on typical patterns of practice in the QIO area, or to use national criteria, where appropriate. See 42 C.F.R. §476.100(c). CMS' presumption that all SSO cases should remain in acute care hospitals lacks factual support and fails to consider which type of hospital care and programs are in the best interest of Medicare beneficiaries. It

irreconcilably conflicts with the statutory and regulatory scheme which delegates to QIOs' the responsibility to establish criteria which are to operate in the best interest of Medicare beneficiaries.

In view of the foregoing MHHS respectfully requests CMS to not adopt the proposed SSO policy for fiscal year 2007. This issue needs to be fully researched not only from the LTCH point of view but the impact this will have on other Medicare providers and let's not forget the Medicare beneficiary access to care.

Sincerely,



H. Jeffrey Brownawell
Vice President of Managed Care and Government Reporting

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CALVARY HOSPITAL

The Model for the Relief of Cancer Pain and Symptoms for Over a Century

Office of the President

March 17, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq.* - CMS-1485-P

Dear Dr. McClellan:

The Calvary Hospital ("Calvary") welcomes the opportunity to submit these comments on proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4727 *et seq.* Calvary is particularly concerned by the draconian proposal whereby the so-called short stay outlier ("SSO") case benchmark of 120 percent of patient costs would be reduced to 100 percent and SSOs would be reimbursed under the inpatient prospective payment system ("IPPS") applicable to acute care hospitals. This proposal, which would apply to Calvary on January 1, 2007, directly threatens the financial integrity of the hospital. Calvary estimates that the proposed SSO policy, together with the proposal for a zero update, will reduce payments to Calvary by approximately 12 percent in fiscal year 2007, forcing Calvary to operate at a loss when treating Medicare patients. The proposal is contrary to Congress' explicit statutory direction that a so-called "subclause II" long-term care hospital (LTCH) such as Calvary be reimbursed under the LTCH-PPS. It is in conflict with Congress' recognition of Calvary as a unique LTCH which specializes in treating cancer patients with a shorter average length of stay than patients in LTCHs generally, and is inequitable as applied to Calvary for reasons that will be detailed below.

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fcalamari@calvaryhospital.org www.calvaryhospital.org

I. Proposed Revisions to SSO payments

A. Statutory and Regulatory Background.

Calvary is singular and unique in its mission as the only hospital in the United States dedicated exclusively to providing medical care and treatment to advanced cancer patients. Congress has recognized the uniqueness of Calvary as a long-stay cancer hospital by not applying the greater than 25 day average length of stay (ALOS) requirement generally applicable to LTCHs to Calvary. Calvary is defined under §1886(d)(1)(B)(iv)(II) of the Social Security Act as follows:

> "a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997."

See also 42 C.F.R. §412.23(e)(2)(ii) and 62 *Fed. Reg. 46016 and 46026* (August 29, 1997). CMS often refers to a hospital meeting the above definition as a "subclause II" LTCH.

The Centers for Medicare and Medicaid Services (CMS) has also appropriately exempted Calvary Hospital from certain other requirements applicable to LTCHs, such as revisions to the way it calculates compliance with the applicable ALOS requirement under 42 C.F.R. §412.23(e)(3). See and compare 42 C.F.R. § 412.23(e)(2)(i) with 42 C.F.R. § 412.23(e)(2)(ii). The passage of these laws and regulations indicates Congress' strong intention that such a unique long-stay cancer hospital deserves special protections to ensure that it will be able to continue its mission. CMS' proposed changes to the SSO policy threaten Calvary's ability to continue its mission.

B. It is Inequitable to Apply the Proposed changes to the SSO Policy to Calvary.

By definition, the patients treated at Calvary have a shorter length of stay than patients treated at other LTCHs. A short stay outlier case is defined as a "stay shorter than 5/6 of the geometric mean length of stay". The majority of Calvary's cases fall within this category.

In the past CMS has acknowledged that based on claims data, over half of the patients treated at Calvary would qualify as short-stay outliers and that the patient census at Calvary will be comprised of an unusually high percentage of short-stay outlier cases.

> "The theoretical foundations of a DRG-based PPS are that while the costs of one case may exceed its payment, the opposite is also likely to happen, and that where some types of cases are always very expensive for a hospital to treat, others are, in general, not costly. It is assumed that hospitals under a DRG-based system, therefore, can typically exercise some influence over their case-mix and their services in order to achieve fiscal stability. This is not generally the case for 'subclause (II)' LTCHs because they continue to primarily treat patients with neoplastic diseases (97.4 percent of patients at a 'subclause (II)' LTCH had primary diagnosis of neoplastic disease, according to data from FY 2001 MedPAR files.). According to our claims data for January 1, 2001, through December 31, 2001, at a 'subclause (II)' LTCH, more than 93 percent of its Medicare patients expired, over half of the patients at this hospital would qualify as short-stay outliers (97 percent of those short-stay outliers expired), and 30 percent of its patient days were for high-cost outlier patients with an average length of stay of 109 days."

68 Fed. Reg. 34122, p. 34147 (June 6, 2003). **CMS has acknowledged that since Calvary cannot control its case mix, Calvary cannot control its length of stay.**

> "As we evaluate the short-stay outlier policy with regard to 'subclause (II)' LTCHs, we believe that a LTCH in this category may not be able to readily address the length of stay of patients and the costs

> it incurs for those patients as would LTCHs described under subclause (I) because a 'subclause (II)' LTCH continues to primarily serve patients with neoplastic diseases."

68 Fed. Reg. at 34148.

In fact, CMS again acknowledges the "specific needs" and the "unique and vital role" of a "subclause II" LTCH "in serving a particular subset of Medicare patients" in the proposed rule. See 71 *Fed. Reg.* at 4685. However, CMS' proposal to apply the 100 percent standard and the IPPS standard to a "subclause II" hospital, namely Calvary, on January 7, 2007, is inconsistent with CMS' acknowledgement. CMS is merely delaying the application of a proposed rule which will have an egregious effect on Calvary for 3 months -- hardly recognition of the "unique and vital role" of a "subclause II" hospital.

The Calvary Hospital cannot control the length of stay of patients it admits by varying patients' case mix since it primarily admits cancer patients. CMS has previously acknowledged this fact by providing for an additional adjustment to the short-stay outlier policy for "subclause II" LTCHs in the rate year 2004 LTCH-PPS final rule by substituting the following SSO percentages during the first 4 years of the 5 year transition period: 195 percent, 193 percent, 165 percent, and 136 percent. During the fifth year the percentage is the same as that for subclause I LTCHs -- 120 percent. *68 Fed. Reg. at 34147-34148.* The only adjustment provided for Calvary in the proposed rule is a three month delay in applying it. Since CMS itself has acknowledged that Calvary cannot control the length of stay of the patients it admits by varying its patients' case mix, it is irrational for CMS to apply a proposed rule to Calvary which presumes that it can do so.

The stated reasons for the proposed changes to the SSO rule are inapplicable to the Calvary Hospital. CMS states the objective of the SSO rule is to preclude the admission of SSO patients to LTCHs. CMS' presumption is that SSO cases should have remained in acute hospitals. 71 *Fed. Reg.* at 4688. As discussed below it is inequitable to apply this presumption to the Calvary Hospital.

It is misguided for CMS to assume that all SSO cases that are admitted to Calvary Hospital should have remained in acute hospitals because of the unique mission of Calvary Hospital to provide end of life care to cancer patients. Also, a significant number of SSO cases are not admitted to Calvary from acute hospitals but rather, at the direction of a patient's attending physician, are admitted from home or a nursing facility. By definition at least 80 percent of Calvary's cases have a principal diagnosis of cancer. Cancer patients have a high mortality rate in comparison to patients who suffer from other illnesses. CMS has provided no rational basis to apply the proposed SSO to a "subclause II" hospital which by definition is entitled to maintain a lower ALOS than other LTCHs and would in fact punish Calvary for admitting a high percentage of patients who expire.

C. The Proposed SSO policy conflicts with the Statutory and Regulatory Scheme that Governs Medical Necessity Determinations.

The proposed SSO rule is an unprecented intrusion on physician decision making and contrary to long standing Medicare principles that govern medical necessity determinations. It would impose a payment adjustment as a mechanism to disqualify a patient for hospital services and intrude upon a physician's ability to admit patients to Calvary based on medical necessity, i.e., the need for specific programs of care and services provided at Calvary.

Further, CMS ignores MedPAC's recommendation contained in its June 2004 report to Congress that CMS designate Quality Improvement Organizations (QIOs) to review the medical necessity of LTCH patient admissions. There is a comprehensive statutory and regulatory scheme which vests QIOs with authority to review the medical necessity of hospital services provided to Medicare beneficiaries. QIOs, which are composed of licensed doctors of medicine, determine, among other things, whether inpatient hospital services furnished to Medicare beneficiaries are consistent with generally accepted standards of medical care, or could be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type and the medical necessity, reasonableness and appropriateness of hospital admissions and discharges. See Sections

1154(a)(1) and (3)(C) and of the Social Security Act and 42 C.F.R. §476.71(a).

The proposed SSO policy conflicts with the principles applied by QIOs to determine whether SSO cases should remain in an acute hospital. QIOs apply professionally developed criteria including screening criteria in making their determinations. See Section 1154(a)(1)(B) and 6(A) of the Act and 42 C.F.R. §476.100. They also assess the appropriate medical care available in the community. See 50 *Fed. Reg.* 15312, 15316 (April 17, 1985). QIOs are required to use national, or where appropriate, regional norms in conducting their review. See Section 1154(a)(6)(A) of the Act and 42 C.F.R. §476.100(a). QIOs also are required to establish written criteria based on typical patterns of practice in the QIO area, or to use national criteria, where appropriate. See 42 C.F.R. §476.100(c). CMS' presumption that all SSO cases should remain in acute care hospitals lacks factual support and fails to consider which type of hospital care and programs are in the best interest of Medicare beneficiaries. It irreconcilably conflicts with the statutory and regulatory scheme which delegates to QIOs' the responsibility to establish criteria which are to operate in the best interest of Medicare beneficiaries.

II. No Fiscal Year 2007 Update

CMS' proposal to provide a zero fiscal year 2007 update, combined with the proposed SSO rule will force Calvary to operate at a loss. At a minimum, it will reduce Calvary's ability to finance medical care and services provided to indigent populations and defray the cost of bad debts. Ultimately, it will threaten Calvary Hospital's ability to survive. It is unfair and unreasonable to deny LTCHs any inflation allowance particularly since the applicable fiscal year 2007 market basket increase is 3.6%. CMS' proposal places the ongoing operation of Calvary in jeopardy.

Calvary otherwise endorses and supports the comments submitted by the National Association of Long Term Hospitals.

In view of the foregoing, Calvary respectfully requests CMS to not adopt the proposed SSO policy and/or to exempt "subclause II" hospitals from the proposed SSO policy and to grant LTCHs a reasonable inflation update for fiscal year 2007. Calvary Hospital thanks you for your consideration of these comments.

Sincerely,

Frank A. Calamari
President/CEO

LIFECARE
HOSPITALS
of FORT WORTH

MAR 2 0 2006

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Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am very concerned about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I am the Director of Respiratory Services at LifeCare Hospitals of Fort Worth and have been in my position for eight years. Previously I was the Assistant Director of Respiratory Services for four years at another long term acute care hospital.

I understand the need for cost effective healthcare in this country and the governmental attempt to curb rising healthcare costs. However, these proposed cost effective measures will drastically affect the LTAC industry and the patients we serve.

LTAC facilities specialize in treating the complex medical needs of the patient. As the baby-boomer generation transitions to 65 the need for LTAC's will increase greatly. Adequate care cannot be provided to this aged population with the proposed cut backs.

I have many examples of successes within the LTAC setting, I'll not bore you but I feel the need to share a few that are outstanding:

- A gentleman was admitted to our facility a few years ago from a nursing home. He had been a patron of the nursing home for 8 years because he had a tracheostomy tube. His wife visited him routinely and he was fairly happy; however, it wasn't home. He became ill and was sent to a short term acute facility and then transferred to our hospital. We cleared the initial issue and he was ready to return to the nursing home. The healthcare team discussed options other than the tracheostomy tube with the physician. No one had addressed his tracheostomy in 8 years. We began the process of weaning him from the tracheostomy tube which he tolerated well. Through the time afforded this patient in the LTAC setting we were able to remove his tracheostomy tube and the patient was able to

return home to his wife. He was so grateful for our efforts that he cried. He now could spend the rest of his days at home with his wife and family.

- Another gentleman was admitted from an out of town hospital. We were the closest LTAC which was 55 miles from this hospital. The previous short term acute hospital informed the patient that he might need a ventilator for sleep. He was sent to us for evaluation and treatment. We diligently worked to find a solution for this patient. He was a college professor with wonderful family support; however, he desired to find an alternative to his current prognosis. We did solve the problem and he returned home with equipment that resolved the issue; not ventilator support.

There are numerous successes such as those illustrated above. LTAC's provide a service to the immediate community and to many of the surrounding areas that is not available elsewhere. Long Term Acute Care Hospitals must be allowed to continue this service to the community with their present reimbursement. Please do not make us provide services with one hand tied behind our backs. You don't want your mother or dad to be a patient in a facility that has lost 15% of its funding. Don't make us cut corners that will compromise care and compromise these fragile patients' changes to recover.

If you or a loved one ever has a need for the services of a long term acute care hospital you can be assured that you will receive these services, not available at any other level of care, efficiently and effectively.

Thank you for your consideration.

Sincerely,

Pat Henderson
Director of Respiratory Services
LifeCare Hospitals of Fort Worth

LIFECARE
HOSPITALS
of FORT WORTH

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule,

Dear Administrator McClellan:

I am very concerned about your proposed rule to reduce Medicare reimbursement to long term acute care hospitals.

I have been the Director of Case Management at LifeCare Hospitals of Fort Worth for eight years and previously worked for six years at another long term acute care hospital. I have also worked in a short term acute care hospital.

From the perspective of my experience in both settings, I feel very strongly that this level of care plays an essential role in the health care continuum. Treatment options for the patients with whom we work are extremely limited. These are very ill patients with complex medical conditions and debilitation. Because they need specialized medical services and daily physician visits, these patients cannot be effectively treated at a lower level of care. Many of them require treatment modalities such as ventilator weaning, dialysis, and intensive wound care that are not available to them in a nursing home setting.

Your suggestion that long term acute care hospitals are seeking out short stay patients is entirely untrue. Because of their medical complexities, it is impossible to determine their response to treatment or the length of time they will need to be hospitalized.

In my role as a Social Worker and as a Director of Case Management, I have seen, time after time, the benefit of this level of care for patients who would otherwise have little or no chance for recovery. I have spoken to their families who had lost hope and have had that hope renewed.

Another very valuable role that we play, for those patients with little hope of recovery, is that of assisting their families to accept this reality and to make the

6201 Overton Ridge Boulevard • Fort Worth, Texas 76132-3613 • Toll Free (866) 537-2273 • (817) 370-6078 • (817) 370-6079 Fax
www.lifecare-hospitals.com

decision to stop further aggressive care. This process does not occur in the short term acute care setting. Assisting with this process ultimately benefits the entire health care system by saving significant costs and resources. Because hospital stays are often shortened by this process, with your proposed rule they would be punished for it, despite its obvious benefit.

If long term acute care hospitals are not available for this group of patients, they will require longer stays or frequent re-hospitalizations, at a higher cost, to a short term acute care hospital.

I hope that you will reconsider this proposed rule which could deny patients access to services vital to their recovery.

I thank you in advance for your consideration regarding this very important matter.

Sincerely,

Gail Berky, LMSW, CCM

Gail Berky
Director of Case Management, LifeCare Hospital of Fort Worth

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March 16, 2006

Honorable Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C-4-26-05
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule, 71 Fed. Reg. 4648

Dear Dr. McClellan:

I am writing in support of the comments submitted on this subject by the Acute Long Term Hospital Association ("ALTHA").

As a business partner to healthcare providers, my company has had the opportunity to view first hand the quality of care delivered by long term acute care hospitals to the most seriously ill patients. They are a vital link in the health care continuum.

The effect of this proposed rule, as I understand it, would reduce payments to these important long term acute care hospitals ("LTACHs") by as much as 11%. A reduction of this magnitude could jeopardize patient access to critical and necessary care.

I would urge reconsideration of the proposed changes to the LTACH prospective payment system ("PPS") in light of the Medicare Payment Advisory Commission ("MedPAC") recommendations released in June 2004. Essentially, MedPAC called for a strengthening of the certification criteria for the Medicare LTACH provider category in order to ensure that payments are being made only to those providers that are administering medically complex care to severely ill patients. At this juncture, such an approach would seem to represent a more considered method for limiting LTACH payments to hospitals that are clearly caring for a medically complex patient population.

1069 STATE ROUTE 46E, BATESVILLE, INDIANA 47006-9167 812-934-7777 Telefax International: 812-934-7191 Telefax Domestic: 812-934-8189

ALTHA has prepared a thoughtful response to the proposed rule and outlines some alternative approaches to LTACH reimbursement. We urge your careful consideration of their comments.

Thank you for the opportunity to express our view.

Sincerely,

Thomas J. Jeffers
Director, Government Affairs

Vicki May

From: Jim Melberg
Sent: Thursday, March 16, 2006 3:23 PM
To: Vicki May
Subject: FW: Medicare Program; Prospective Payment for Long-Term Care Hospitals RY 2007; Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule, 71 Fed Reg. 4648
Attachments: Letter to Honorable Mark B McClellan.pdf

From: Bev_Lamping@hill-rom.com [mailto:Bev_Lamping@hill-rom.com]
Sent: Thursday, March 16, 2006 3:15 PM
To: Jim Melberg
Cc: Tom_Jeffers@hill-rom.com
Subject: Medicare Program; Prospective Payment for Long-Term Care Hospitals RY 2007; Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule, 71 Fed Reg. 4648

I am attaching a copy of a letter from Tom Jeffers. Please let me know if you have any questions or need anything further from me.

Thank you.

Bev Lamping
Hill-Rom Legal
Administrative Assistant
Ph: 812-934-8147
Fax: 812-934-1633
e-mail: bev_lamping@hill-rom.com

March 13, 2006

Form letter # 37

MAR 20 2006

Honorable Mark B. McClellan
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
7500 Security Boulevard
Baltimore, MD 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

It has come to my attention that CMS is considering a reduction in the reimbursement to long term acute care hospitals. I am greatly concerned about and oppose your proposed rule.

I am the Quality Manager for LifeCare Hospitals of North Texas-Fort Worth. During the past seven years, I have had the opportunity to review over 3,000 LHNT-Fort Worth patient / family satisfaction surveys . There has been a consistent and constant theme in the comments made by Medicare patients and families that have benefited from the extensive care received in our long term acute care hospital. Time and time again patients and families have written, "You saved my life." "You gave me back my wife/husband." "Thank you – thank you for healing my horrible wound." "We do not know what we would have done if your hospital had not been there to help us – my wife was too sick to be cared for in a nursing home and she was being discharged from the acute care hospital – we did not know what to do. LifeCare was a God send for us. My wife is now back home and doing well." "I can walk again, thanks to LifeCare." "Thank you-LifeCare for being there when we needed help so desperately for our mother."

In reviewing patient outcomes, I have found that LifeCare has amazing outcome results. A large percentage of our patients with severe complex illnesses return to their homes to have quality time with their families. Ongoing utilization review results have shown that LifeCare has provided care that is safe, effective, patient-centered, timely, efficient, and equitable for Medicare patients with multiple co-morbidities

The effect of this proposed rule, as I understand it, would reduce payments to the important long term acute care hospitals by as much as 15%. This drastic action could jeopardize patient access to critical and necessary care, and may even force these hospitals to close their doors. Your decision could profoundly affect thousands of patients deserving of the care they need. In my opinion, Medicare has an ethical obligation to continue providing the benefits of long term acute care.

I am gravely worried and oppose your proposed rule to reduce Medicare reimbursement to long term acute care hospitals. Services provided in a long term acute care hospital are essential for the treatment of thousands of patients in need of specialized acute care requiring a length of stay of 25 days or greater. The important care that long term acute care hospitals provide must remain available for families in need; otherwise, our nation may experience a healthcare disaster with a longstanding and detrimental impact on the entire healthcare system.

Please do not jeopardize the future of these critical hospitals.

Sincerely, Vickie D. Pflueger, RN, CPHQ

Vickie D. Pflueger, RN, CPHQ, Quality Manager; LifeCare Hospitals of North Texas – Fort Worth,
6201 Overton Ridge Blvd, Fort Worth, Texas 76132

HOSPITAL for EXTENDED RECOVERY
Affiliated with SENTARA

Hospital for Extended Recovery
600 Gresham Drive, Suite 700
Norfolk, Virginia 23507

MAR 20 2006

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March 9, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: Comments on Medicare Program; 2007 Proposed Update Rule Published at 71 Federal Register 4648 *et seq.*

Dear Dr. McClellan:

The Hospital for Extended Recovery submits these comments on proposed rules published on January 27, 2006 at 71 *Fed. Reg.* 4648 et seq. This rulemaking seeks to make significant changes to the admission practices of long-term care hospitals (LTCHs) as well as payment policies. The Hospital for Extended Recovery was established in December, 2001, and is located at 600 Gresham Drive; Norfolk, VA. It serves a significant percentage of Medicare patients residing in the Hampton Roads Virginia Region. CMS' proposed short-stay outlier rule and zero update proposal would drastically reduce payments to Hospital for Extended Recovery in fiscal year 2007. In FY 2007, with the continued phase in of the 25% rule, the zero update factor and the SSO rule, our facility will be at risk of closure. The facility will not be able to compete with difficult to recruit positions such as pharmacists, therapists and nurses and the lack of funding will prevent the facility from the ability to replace much needed capital equipment such as ventilators.

Hospital for Extended Recovery has provided excellent care to the individuals who have come under our care. Our clinical quality indicators are better than the majority of providers in our region. We take pride in achieving very low hospital acquired complications (ventilator associated pneumonia, decubitus ulcers, and infections). Many of our patients and families have described our service as the only thing "saving" their loved one. We have admitted several patients that were believed to be "ventilator dependent". However with a multi-disciplinary treatment approach, the patients were weaned off the ventilator and discharged to their home environments. We have a multitude of success stories to put faces on the dollars that you are trying to save.

Patients have the right to have access to specialized care. Administrative criteria and payment schemes should NOT be how we determine if facilities should remain open or close their doors OR if patients should receive treatment or not. ONLY CLINICAL criteria should be used to make these decisions. QIO reviews for Medical Necessity criteria will force facilities to admit appropriate patients or close their doors. The Hospital for Extended Recovery **URGES** CMS to **NOT** adopt the proposed short-stay outlier rule and zero update proposal because the continued operation of Hospital for Extended Recovery and the patients it serves will be placed in jeopardy if they are adopted.

Short-Stay Outlier Proposal

CMS states the objective of the Short-Stay Outlier (SSO) rule is to preclude admission of SSO patients to LTCHs. CMS' presumption is that SSO cases should have remained in acute hospitals. 71 Fed. Reg. at 4688. As discussed below this presumption is wrong.

Through the SSO policy CMS has assumed that SSO patients in LTCHs are similar to short-term acute hospital patients assigned to the same DRGs. To the contrary SSO patients have a relative case-mix index of 2.0592 which is 110% greater than the relative case-mix index of 0.98734 assigned to patients with the same DRGs in short-term acute hospitals. These SSO patients therefore have a higher medical acuity and use more medical resources than are reflected in short-term hospital payments. The higher acuity of LTCH SSO cases is further demonstrated by a higher death rate of 19.61% for SSO cases in LTCHs vs. 4.81%. The average length of stay of SSO cases in LTCHs is 72% greater (12.7 days vs. 7.4 days) than the average stay in short-term acute care hospitals.[1]

CMS also assumes that LTCHs are able to predict, prior to admission, which patients will become SSOs. There is no way for LTCHs to make such a prediction. Long-term care hospital patients suffer from multi-system body failures with peaks and valleys in their medical conditions. Their conditions may unpredictability improve or deteriorate at any time. SSO cases are admitted to LTCHs at the appropriate level of care based on the medical judgment of their treating physicians. It is impossible to pre-screen patients and effectively identify which patients may become SSOs. There are a myriad of reasons why a patient admitted to an LTCH may become a SSO. Some SSO cases may achieve medical stability sooner than originally expected. Other cases may become SSOs because they require discharge to an acute hospital due to a deteriorating condition or a new condition which develops subsequent to their admission to an LTCH. Other patients admitted to LTCHs from acute care hospitals may become SSO cases due to their unexpected death. Some patients and their families, after realizing the gravity of their condition, may simply give up and request that aggressive treatment be stopped after admission.

There is no basis for a proposed rule which assumes that SSO cases should have remained in acute hospitals. CMS ignores the fact that a significant number of SSO cases are not admitted from acute hospitals but rather, at the direction of a patient's attending physician, are admitted from home or a nursing facility. It is inappropriate for CMS to presume that a patient admitted to an LTCH from a non-acute hospital setting, at the direction of the patient's attending physician, who subsequently becomes a SSO should not have been admitted to the LTCH in the first place.

CMS also disregards the fact that a percentage of SSO cases are crossover cases that exhaust Medicare Part A benefits during their LTCH stay. It would be unfair to

[1] This data is obtained from a March 3, 2006 report by The Lewin Group prepared for the National Association of Long Term Hospitals.

MAR 20 2006

39.

QUINCY MEDICAL CENTER
The Boston Medical Center Alliance For Quality
TRULY REMARKABLE

March 20, 2006

Mark McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: Prospective Payment System for Long Term Care Hospitals, Rate Year 2007

Dear Administrator McClellan:

Quincy Medical Center is writing to express our serious concern with the Rate Year 2007 Long Term Care Hospital ("LTCH") Prospective Payment System Proposed Rule. In its current form, we strongly believe that this rule will seriously jeopardize the ability for severely ill and medically complex Medicare patients to access specialized services and programs of care that may not otherwise be available in other alternative sites of care.

LTCHs serve a significant percentage of Medicare patients residing in Massachusetts and play a vital component of the State's health care system. There is ample evidence that LTCHs provide high quality outcomes for patients by focusing on their acute needs and assisting them to achieve medical stability. This proposed rule inappropriately focuses solely on whether savings to the program can be actualized by using payment criteria to define clinical determinations of hospital level of care.

The proposed changes to the short-stay outlier rule will negatively impact the ability of acute care hospitals to manage and treat patients in an efficient manner. This rule further penalizes an LTCH for making good faith appropriate medical assessment of patients who need long term acute care services. If implemented, this rule will further create increased backup of patients in acute hospitals by increasing the retention of patients in acute hospital ICU and other critical care units long beyond the need for an acute care hospital level of stay.

Quincy Medical Center supports the comments and proposals provided by the Massachusetts Hospital Association, and urge you to adopt them in the final rule.

Thank you for the opportunity to comment on the proposed rule.

Sincerely,

Gary W. Gibbons, MD
President and Chief Executive Officer

Mark Gronberg, FACHE
Vice President and Chief Financial Officer

LOUISIANA HOSPITAL ASSOCIATION

JOHN A. MATESSINO
PRESIDENT & CEO

9521 BROOKLINE AVENUE • BATON ROUGE, LOUISIANA 70809-1431
(225) 928-0026 • FAX (225) 923-1004 • www.lhaonline.org

March 17, 2006

MAR 20 2006

Mark McClellan, M.D., Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Attn: CMS–1485–P
P.O. Box 8011
Baltimore, MD 20244-8011

RE: Medicare Program; Prospective Payment System for Long-Term Care Hospitals: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule.

Dear Dr. McClellan:

The Louisiana Hospital Association (LHA) appreciates the opportunity to comment on the proposed rule concerning the long-term care hospital prospective payment system (LTCH PPS) for rate year (RY) 2007. The proposed rule recommends several significant changes that are of concern to the LHA and its LTCH hospital members – most notably the proposal to omit the 3.6 percent market basket update and proposed changes to the short-stay outlier (SSO) policy. The alarming net impact of this proposal is excessive and would severely and inappropriately threaten patient access to LTCH care.

The LHA supports the introduction of a new market basket methodology for the LTCH PPS – the rehabilitation, psychiatric and long-term care (RPL) market basket. While we support this more targeted and current measure of inflation for the LTCH PPS, we have some reservations about the new methodology. For instance, to develop the RPL market basket the Centers for Medicare & Medicaid Services (CMS) had to piece together sufficient data for each of the represented provider types by using disparate length of stay trimming methodologies. CMS also filled in data gaps by substituting inpatient PPS data. Thus, we encourage CMS to work with providers to improve the RPL cost reports to eliminate the need to use proxy data from the inpatient PPS. We urge CMS to update the RPL market basket on a regular basis, especially since these providers have only recently converted to prospective payment and their cost structures may be changing.

Annual market basket updates are intended to compensate for year-to-year inflationary increases in the cost of delivering health care services. An annual inflationary update to the LTCH PPS, and all prospective payment systems, is essential to maintaining an accurate payment system that helps providers safely care for patients. As such, it is wholly inappropriate to exclude a market basket update for LTCHs in RY 2007, as recommended by the proposed rule. The RY 2007 market basket calculation of 3.6 percent under both the RPL market basket method and the current methodology validates the real inflation costs LTCHs will face next year, which must not be overlooked in the

final rule. In addition, to omit the market basket update to offset coding changes is a misuse of the market basket.

An essential principle for all Medicare prospective payment systems is that payments are based on the average cost of all patients treated under that system, given the clinical characteristics and the cost of treatments associated with a particular group of patients. For the system of averages to be fair and sustainable, patients with below-average costs are needed to offset losses experienced for patients with above-average costs. The significance of upholding this principle has been validated by CMS on many occasions.

When the LTCH PPS was introduced in 2003, the agency stated in the *Federal Register* that paying for cases treated in excluded hospitals, such as LTCHs, under the inpatient PPS would be "inaccurate and unfair" since these cases were not included in the inpatient PPS system of averages. The agency also noted that paying LTCHs under the inpatient PPS could result in the systematic underpayment of LTCHs. We support CMS' views and therefore, as discussed below, feel that **the proposed SSO changes would violate the integrity of the LTCH PPS by applying inpatient PPS rates to an LTCH population that is dramatically different from the inpatient PPS population.**

In addition, it is critical that each Medicare PPS sets payments at a level that covers the cost of providing care. Doing so helps ensure that providers have the resources to deliver appropriate care in a safe manner. Under this proposed rule, CMS would exclude the 3.6 percent market basket update and reduce overall LTCH payments by 11.1 percent, largely through the proposed SSO changes. Based on analysis by The Lewin Group, **the combined impact of CMS' recommendations for RY 2007 would lower Medicare payments to LTCHs to 5 percent below the cost of providing care. This unjustifiable outcome would irresponsibly threaten the ability of providers to safely care for their patients.**

CMS proposes to significantly modify the LTCH SSO policy, which is intended by CMS to discourage LTCHs from admitting short-stay cases. SSO cases have a duration that is up to 5/6 of the geometric mean length of stay (ALOS) for a particular LTCH diagnosis-related group (DRG). Currently, SSO cases are paid the lesser of the following:

- the full LTCH DRG payment;
- 120 percent of the LTCH DRG per diem; or
- 120 percent of the cost of the SSO case.

CMS proposes to modify the current SSO policy in two ways:

- lower the SSO case reimbursement based on 120 percent of cost to 100 percent; and
- add a new, and substantially lower, payment alternative – an amount "comparable" to the DRG rate under the inpatient PPS.

The proposed SSO policy falsely equates a short-stay outlier case as an inappropriate LTCH admission. The rule overlooks the fact that by its very design, the LTCH PPS presumes a range of lengths of stay including cases above and below the ALOS. CMS states its concern that SSO cases represent 37 percent of all LTCH cases and that SSO cases "may indicate a premature discharge from the acute-care hospital and an unnecessary admission to the LTCH." However, length of stay on its own is neither an effective nor insightful indicator of medical necessity.

Given that the definition for SSO cases includes 5/6, or 83 percent, of the cases with a LOS below the mean, CMS should presume that a significant proportion of all LTCH cases would fall within the SSO range. The agency should not expect that the 37 percent rate of SSO cases would continue to drop indefinitely, given the current SSO definition. If CMS wants to see the percentage of SSO cases decline further, then the definition for SSO cases needs to be changed.

CMS states that by treating SSO cases LTCHs may be "functioning like an acute care hospital." However, in taking this position CMS has overlooked essential differences between the LTCH case mix, including SSO cases, and the case mix treated by hospitals under the inpatient PPS. For instance, The Lewin Group has compared common LTCH and inpatient PPS DRGs and found that the case-mix index (CMI) for LTCH SSO cases is more than double the CMI for general acute hospitals.

A dramatic difference also is found when comparing ALOS. LTCH SSO cases have an ALOS that is more than twice as long as the ALOS for inpatient PPS hospitals, 12.7 days versus 5.6 days, respectively. Analysis by Avalere Health using All Patient Refined DRGs found that for both the total LTCH population and the LTCH SSO population, the presence of the highest levels of medically complex patients (Levels 3 and 4) is approximately double the rate found in general acute hospitals. Similarly high severity levels for both the LTCH population and LTCH SSO cases highlight the inability of referring general acute hospitals and admitting LTCHs to identify SSO cases upon admission to the LTCH. This *reality* of treating severely ill patients directly challenges CMS' assertion that all SSO cases result from *intentionally* inappropriate transfers to LTCHs. In addition, these data make a clear case that the **patients treated in LTCHs, including SSO cases, are fundamentally different than the patients treated in general acute hospitals.**

These analyses of patient severity and cost also validate the need for a separate LTCH payment system with weights and rates based on the distinctly unique population treated by LTCHs. The studies affirm the inappropriateness of applying an inpatient PPS payment – based on the average cost of treating an entirely different set of patients – to LTCHs. The inpatient PPS rates, even when adjusted for outliers, are not designed or intended for the high-complexity, long-stay population treated in LTCHs. As such, **the agency's proposal to include inpatient PPS rates among the payment alternatives for SSO cases is unjustifiable since it is in direct violation of the Medicare principle of establishing payments based on the average cost of treating specific types of**

patients. And in this case, the LTCH and general acute populations are distinctly unique from one another.

The LHA appreciates the opportunity to comment on this proposed rule. We are committed to improving the LTCH PPS and look forward to working with CMS toward this goal.

Sincerely,

John Mattessino

John A. Mattessino
President and CEO
Louisiana Hospital Association

Form letter #41

MAR 20 2006

March 17, 2006

VIA OVERNIGHT DELIVERY

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS 1485P, "Other proposed policy changes for 2007 LTCH PPS Rate Year, Proposed Adjustment for Specific Cases, Adjustments for SSO Cases"

Dear Administrator:

This letter represents certain comments and recommendations from Triumph HealthCare to key aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs) for FY 2007. I have outlined below the fundamental issues which we believe to be severe and arbitrary.

Although there are many policy changes proposed and contemplated in this proposed rule, and I will have additional comments on those in a later letter, this letter will focus entirely on the "Adjustment for SSO Cases and Proposed Changes to the Method for Determining the Payment Amount for SSO Cases." My attention in this letter will focus primarily on the use of Short Term Acute Hospitals (STAC) IPPS system for Short Term Outliers (SSOs) of LTCHs, or as CMS refers to it, a payment system comparable to STAC IPPS.

When congress originally excluded LTCHs from IPPS in 1983 (and CMS originally issued regulations for LTCHs) they were excluded because of the vastly different types of patients treated and resources consumed. Specifically, CMS stated that this exclusion from IPPS was because the use of IPPS for LTCH "would be inaccurate and unfair" and was "not designed to account for types of treatment" found in LTCHs (Aug. 31, 2002 FR, Vol.67, No.169, p.55957). CMS itself in 2002 said that applying IPPS to LTCHs could "systematically underpay" LTCHs "if the same DRG system were applied to them." (August 31, 2002 Fed. Reg.)

With the proposed rule, CMS is now completely reversing position and proposing that LTCHs be paid IPPS rates for 37% of the patients treated in LTCHs (SSOs). Clearly when 37% of patients are paid a rate of less than 43% of the actual costs to provide care, hospitals will suffer severely, and ultimately so will patients, families, nurses, physicians, and the community at large. *This*

proposal will endanger the most vulnerable and fragile patients in our society and likely the industry as a whole. CMS is proposing to pay LTCH IPPS rates for SSOs based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care provided by LTCHs across the country.

This proposal is based upon numerous erroneous assumptions such as:

1. **LTCHs are taking "premature and inappropriate" patients that have not received their full care from the STAC.**

In fact, admissions to LTCH from STAC hospitals actually had over double the average length of stay in the STAC hospital than the STAC average for those same DRGs. Specifically, patients admitted to an LTCH from a STAC hospital averaged more than a 13-day stay in the STAC before admission to LTCH vs. the geometric mean of those same DRGs in STAC of 6 days. Therefore, LTCH patients had twice as long a hospitalization as normal in the STAC to receive their normal amount of care before admission, a direct contrast to the "premature and inappropriate" accusation. In addition, since the 2004 Medpar data that was used in this analysis, CMS has added an additional 200 DRGs under the Transfer Regulations that will further discourage STACs from making premature discharges to LTCH. The impact of the additional transfer DRGs was not even considered in this proposed rule. Even though these SSO patients have had an extensive stay in STAC before admission to LTCH they are still severely ill. Under the new AP-DRG system the percentage of severely ill patients in LTCH is double that of the STAC, 66%LTCH vs. 33%STAC (% of APDRG Severity of Illness (SOI) categories 3&4)

2. **LTCH SSOs are predictable and hospitals are admitting them because of an "inappropriate financial incentive" and are admitting patients "with lengths of stay more typical of an acute care hospital."**

In fact, average length of stay for SSOs in LTCHs is 13.1 days vs. geometric mean length of stay (GMLOS) in STAC for the same DRGs of 6.1 days. Therefore, the LTCH patients have a length of stay averaging over twice the length of stay in STAC for the same DRG. The patients being admitted to LTCH are not the same and should not be treated the same as the general population of the STAC.

A significant portion of LTCH SSOs are patients that unfortunately, and unexpectedly, die. For Triumph, 24% of our SSOs are attributable to deaths. The faulty assumption has been that LTCHs can predict deaths and are taking these SSOs intentionally. *This could not be further from the truth.* Because of the severity of illness of LTCH patients and the number of co-morbidities, the predictability of length of stay and death is much less accurate than in STAC. In fact, even in STAC there are a large number of early deaths when compared to GMLOS. While clinicians may exercise sound judgment and have "gut feels", there are no accurate tools available for predicting mortality in an LTCH setting. The need for LTCHs to exceed the 25 day

LOS also undercuts the argument that LTCHs intentionally take short stay deaths. LTCHs sometimes unexpectedly have a 25-day problem. Almost always it is because of unexpected deaths.

The patients are severely ill with 66% of SSOs in LTCHs in AP-DRG severity of illness categories (SOIs) of 3(major) or 4(extreme) compared to STAC average of 33%. LTCH patients average at least one more co-morbidity than the STAC average and patients are two years older than even the average age of outliers in STACs.

Additionally, more than 10% of Triumph SSOs were already outliers in STAC before admission to LTCH, certainly not early discharges from a STAC facility. More than 7% of SSOs had greater than a 25-day length of stay, hardly a typical stay at a STAC facility.

3. **37% of patients in SSOs is "inappropriately high."**

CMS utilized FY 2004 Medpar data to develop the payment policies included in the proposed rule, which only reflected the first year of transition into PPS for LTCHs, and a substantial number of LTCHs had not even fully transitioned to PPS in FY 2004. With one year of data, CMS concludes that SSOs in LTCHs have dropped from 48.4% to some 37% one year post transition to PPS. A drop from over 48% to 37% would hardly suggest that the payment policies in place were not having the desired effect. Recent data released by Lewin shows that STACs have 40% of their cases shorter than 5/6 of their GMLOS, so is this inappropriately high? Of course not, it is the nature of the bell curve and the PPS system that some patients fall below and some fall above the mean. A cutoff was chosen (5/6) related to the cost methodology (120% of cost) and the desire not to create a cliff. Then the original % was noted (48.4%), then the drop was noted (37%), and then a new formula was created (IPPS for SSOs) *based on no identifiable data or appropriate methodology*. Even though the lengths of stay compared to STAC are more than double, the severity of illness in LTCH is also double that of STAC. Many cases are already outliers in STAC before admission to LTCH, many SSOs are unpredictable deaths and a sizable number have more than a 25-day length of stay in LTCH, yet CMS proposes to pay LTCHs via a system developed for a completely different patient population.

Assessment of IPPS for LTCH

This payment methodology also will create a "cliff" (just what CMS did not want to do) just before the 5/6 point because it is based on STAC IPPS which has a very short GMLOS. The average length of stay in STAC is 5.3 days versus LTCH of over 25 days. The proposed payment methodology would generally pay a full IPPS DRG payment at 6 days and no additional payment until the 5/6 point or at least 22 days. That is 16 days without additional reimbursement. The vast majority of these patients do not hit outlier status in LTCHs (81% of SSOs will be paid under proposed IPPS) and the closer they get to the 5/6 the lower the payment per day is until the difference (between full pay and IPPS pay) the day before the full LTCH

DRG is the largest "cliff". This is directly contrary to your own opinion (71 FR 4686) where you state supportively that the cost methodology "which results in a gradual increase in payment as the length of stay increases without producing a payment "cliff" at any one point, provides a reasonable payment option under the SSO policy." The IPPS methodology when applied to SSOs creates exactly this cliff the longer the patient stays past the GMLOS for STAC and the closer they get to 5/6. We have already established that the average length of stay for SSOs is over double STAC GMLOS. The interaction of the lower of cost or IPPS will result in the perverse financial incentive of maximizing SSO reimbursement at the geometric method length of stay for STAC or around 6 days. **Given your theory of "inappropriate financial incentives" you should expect average SSO length of stay to be around 6 days in LTCHs based on this perverse economic incentive.**

The result will be limiting access to care for any type of diagnosis/treatment that might have a long stay but has a substantial portion of that type of patient having a 17-18 day length of stay, such as ventilator (DRG 475). Too many of these SSOs will cause a hospital to go under even though the majority might meet the GMLOS and those that missed only missed by a few days. *The most fragile, older, most unpredictable, and most vulnerable patients would be the most at risk.* SSO patients are older, sicker, more intense, more unpredictable, more likely to die and thus are the types of patients LTCHs are supposed to admit and care for. However, a significant percentage have the unfortunate problem of unexpected death or other unexpected outcomes.

Even though a cursory analysis of the data would prove the above points, CMS is proposing paying LTCHs on average 43% of costs for SSOs. In fact, the longer the stay the less the pay per day. The reason we admit them now is not because of our "inappropriate financial incentive" or desire to get "premature and inappropriate" admissions but because these patients need our specialized care, are no longer appropriate for STAC, and we believe that they would benefit clinically from our services. Although our SSO patients are sicker and length of stay is twice as long as STAC, we would be paid less per day the closer the patient gets to the LTCH GMLOS.

Alternatives and Conclusion

CMS should implement a method as proposed by MEDPAC designed to tighten clinical and facility criteria to address the concerns about clinical appropriateness. Triumph and the industry as a whole are concerned about this as well. We would welcome the chance to work together with CMS on this issue. CMS should release and use the RTI analysis to develop proposals rather than initiating this vast change without this study. If CMS is concerned about very short stays it should use a variation on the original proposed regulation on LTCH PPS which is to have a separate, lower payment for up to 7 day stays. That is, pay a lower percentage of cost for these very short stays as is done for high cost outliers. CMS should use the cost methodology for all SSOs even though we don't find it desirable. It is, however, much better and more appropriate for SSOs, relates to length of stay, and does not create a cliff as STAC IPPS does. QIOs should be held to their responsibility of enforcing clinical criteria and monitoring LTCHs to ensure

appropriateness. We believe the combination of the above alternatives would slow the growth of the industry, meet many of CMS's concerns, and ensure the appropriateness of patients in LTCHs as well.

In closing, CMS should work with the industry, not seek to destroy it.

Sincerely,

Karen L. Messina
Human Resource Director
CLA/dkl

Form letter #42

3)

NORTHEAST PENNSYLVANIA EMERGENCY RESPONSE GROUP

HOSPITAL & HEALTHCARE SUBCOMMITTEE

MAR 2[illegible] 2006

March 17, 2006

VIA OVERNIGHT DELIVERY

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS 1485P, "Other proposed policy changes for 2007 LTCH PPS Rate Year, Proposed Adjustment for Specific Cases, Adjustments for SSO Cases"

Dear Administrator:

This letter represents important commentary regarding key aspects of the proposed annual payment rate updates, policy changes, and clarifications under the prospective payment system for long-term care hospitals (LTCHs) for FY 2007. I have outlined below a few fundamental issues which should be reviewed with additional scrutiny.

When congress originally excluded LTCHs from IPPS in 1983 (and CMS originally issued regulations for LTCHs) they were excluded because of the vastly different types of patients treated and resources consumed within the LTAC environment. Specifically, CMS stated that this exclusion from IPPS was because the use of IPPS for LTCH "would be inaccurate and unfair" and was "not designed to account for types of treatment" found in LTCHs (Aug. 31, 2002 FR, Vol.67, No.169, p.55957). CMS itself in 2002 said that applying IPPS to LTCHs could "systematically underpay" LTCHs "if the same DRG system were applied to them." (August 31, 2002 Fed. Reg.)

With the proposed rule, CMS is now completely reversing position and proposing that LTCHs be paid IPPS rates for 37% of the patients treated in LTCHs (Short Stay Outliers, SSOs). Clearly when 37% of patients are paid a rate of less than 43% of the actual costs to provide care, LTACs will suffer severely, and ultimately so will patients, families, nurses, physicians, general acute care hospitals and the community at large. *This proposal will endanger the most vulnerable and fragile patients in our society and likely the industry as a whole.* CMS is proposing to pay LTCH IPPS rates for SSOs based on faulty assumptions, insufficient data, and a fundamental lack of understanding of the valuable care provided by LTCHs across the country.

A significant portion of LTCH SSOs are patients that unfortunately, and unexpectedly, die. The faulty assumption has been that LTCHs can predict deaths and are taking these SSOs intentionally. *This could not be further from the truth.* Because of the severity of illness of LTCH patients and the number of co-

morbidities, the predictability of length of stay and death is much less accurate than in STAC. In fact, even in STAC there are a large number of early deaths when compared to GMLOS. While clinicians may exercise sound judgment and have "gut feels", there are no accurate tools available for predicting mortality in an LTCH setting. The need for LTCHs to exceed the 25 day LOS also undercuts the argument that LTCHs intentionally take short stay deaths.

The patients are severely ill with 66% of SSOs in LTCHs in AP-DRG severity of illness categories (SOIs) of 3(major) or 4(extreme) compared to STAC average of 33%. LTCH patients average at least one more co-morbidity than the STAC average and patients are two years older than even the average age of outliers in STACs.

The result will be limiting access to care for any type of diagnosis/treatment that might have a long stay but has a substantial portion of that type of patient having a 17-18 day length of stay, such as ventilator (DRG 475). Too many of these SSOs will cause a hospital to go under even though the majority might meet the GMLOS and those that missed only missed by a few days. *The most fragile, older, most unpredictable, and most vulnerable patients would be the most at risk.* SSO patients are older, sicker, more intense, more unpredictable, more likely to die and thus are the types of patients LTCHs are supposed to admit and care for. However, a significant percentage have the unfortunate problem of unexpected death or other unexpected outcomes.

CMS should implement a method as proposed by MEDPAC designed to tighten clinical and facility criteria to address the concerns about clinical appropriateness. CMS should release and use the RTI analysis to develop proposals rather than initiating this vast change without this study. QIOs should be held to their responsibility of enforcing clinical criteria and monitoring LTCHs to ensure appropriateness.

In closing, CMS should strengthen the platform from which patients are selected for admission to LTACs and increase the accountability of the QIOs.

Sincerely,

Don Strubeck
Northeast PA Emergency Response Group
Hospital and Health Care Subcommittee chair

Moses Taylor Hospital
Emergency Management
700 Quincy Avenue
Scranton, PA 18510-1798

HEALTHSOUTH®

March 20, 2006

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1485-P
P.O. Box 8012
Baltimore, Maryland 21244-8012

Re: Medicare Program; Prospective Payment System for Long-Term Care Hospitals RY 2007: Proposed Annual Payment Rate Updates, Policy Changes, and Clarification; Proposed Rule

Dear Administrator McClellan:

HealthSouth Corporation is one of the nation's largest providers of outpatient surgery, diagnostic imaging and rehabilitative healthcare services. We currently operate ten (10) long-term care hospitals ("LTCH"). We are pleased to present the following comments on the January 27, 2006 notice of proposed rulemaking ("NPRM") related to the "Proposed Changes to the Long-Term Care Hospital Prospective Payment System for RY 2007."

The Federation of American Hospitals ("FAH"), Acute Long Term Care Hospital Association ("ALTHA") and the American Hospital Association ("AHA").

HealthSouth is an active member of FAH, ALTHA and the AHA. All of these trade associations have submitted separate comments on this NPRM, and their comments are supported by HealthSouth.

SUMMARY AND RECOMMENDATIONS

For the reasons described more fully below, we recommend that the Centers for Medicare and Medicaid Services ("CMS") withdraw certain aspects of the proposed changes to payment formulas under the LTCH prospective payment system ("PPS"), inasmuch as the implementation of the NPRM may hinder the long-term development of more effective and efficient payment policies under the LTCH PPS.

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1. **Development of Evidence-Based Patient Admission Criteria**. HealthSouth has long supported the Medicare Payment Advisory Commission's ("MedPAC") recommendation to Congress first made in June 2004, that CMS further define "facility and patient criteria to ensure patients admitted to LTCHs are medically complex and have a good chance of improvement." CMS has engaged Research Triangle Institute, International ("RTI") to study the differences in post-acute "patient populations, utilization patterns, outcomes, and Medicare program payments by site of care, and to develop a profile of the LTCH admission in 2003." Because the results of this study will be available within several months, we believe that many of the changes included in this proposed rule are premature. The adoption of uniform, evidence-based admission criteria will address many of the issues identified in the proposed rule more precisely and effectively – and with far less dislocation to beneficiaries and providers.

2. **Short Stay Outlier ("SSO") Payment Policy Changes**. The proposed rule appears to assume that LTCH providers have the ability to determine at the time of admission which cases will end with a SSO episode, end in mortality, or end at or in excess of the full geometric mean length of stay ("GM LOS"). In fact, HealthSouth does not presently have this capability; we presume other LTCH providers are similarly disadvantaged. LTCHs generally apply the same types of admission criteria for ALL admissions which are designed to identify medically complex patients that have a good chance of improvement. Beyond these basic criteria, our staff have not been able to identify additional reliable correlations or predictive factors to indicate which patients are likely to be discharged prior to or after the GM LOS. All that can be determined at admission is that patients are or are not appropriate for LTCH care. However, this determination is based on tools and criteria developed at the facility level, as no standard LTCH admission criteria have been developed. The NPRM fails to present any objective research or data that would give physicians or providers any guidance on SSO screening criteria. LTCHs cannot and should not be required to engage in non-evidence-based probability analysis to determine which patients are appropriate for admission. This is fundamentally unfair to both patients and to providers. As articulated above, the only logical solution to this issue is the development of uniform, evidence-based admission criteria.

   The fundamental design of any effective PPS is the ability to have a geometric distribution of cases that, in the aggregate, covers the cost of caring for all Medicare beneficiaries. The proposed changes in this NPRM would prevent LTCH providers from recovering the cost of care for the majority of discharges not meeting 5/6th of the GM LOS. The proposed rule would create an artificial payment "cliff" in which a one or two day difference in LOS could easily yield payment shortfalls in excess of 59 percent of cost. This ignores the premise that all prospective payment systems presume a bell shaped distribution of cases around the GM LOS. By dramatically underpaying cases below the GM-LOS, we

are concerned that the proposed changes will undermine the integrity and efficiency of the LTCH PPS as a whole.

3. **Market Basket Changes.** HealthSouth supports the adoption of the Rehabilitation, Psychiatric, and Long-Term Care ("RPL") market basket approach based on FY 2002 cost report data. We continue to support any market basket change that more closely matches Medicare payments to the inflation of caring for our patients.

4. **Market Basket Freeze.** We believe CMS has not made an adequate case for a market basket freeze. The NPRM appears to justify a freeze in RY 2007 on the premise that the industry experienced improvement in case mix coding (both "real" and "apparent") since the inception of the LTCH PPS. At the same time, CMS proposes to postpone until July 1, 2008, the implementation of a one-time adjustment to LTCH PPS rates under 42 C.F.R. §412.523(d)(3) to account for differences between actual and estimated payments for the first year of the LTCH PPS due to coding or other factors. This approach is contrary to the design of the LTCH PPS and undermines the integrity and predictability of the payment system.

   We recommend that the proposed rule be amended to include a market basket update tied to actual wage and supply cost increases. If CMS believes that a one-time adjustment under 42 C.F.R. §412.523(d)(3) is necessary, the data and support for this adjustment should be the subject of a separate rulemaking through which all affected parties will have the opportunity to assess the justification for such an adjustment and to offer comments.

5. **Financial Impact**. The NPRM impact analysis table[1] indicates that LTCHs will experience an 11.3 percent reduction in Medicare payment rates as a result of the proposed rule. Taking into account a zero market basket update and the relative weight changes implemented effective October 1, 2005, the net payments to LTCH providers effective on July 1, 2006 will be approximately 20 percent lower than they were on September 30, 2005, on an inflation adjusted basis. This level of payment reduction – entirely by administrative action – is unprecedented among the various Medicare payment systems. Although CMS's concerns with the rapid growth of LTCH services are made clear in this proposed rule, no empirical data are offered to justify the type or magnitude of the proposed changes in payment policy. We believe that substantially more data and analysis is required (*e.g.*, the RTI study) before putting access to care at risk for thousands of Medicare's sickest and most vulnerable beneficiaries.

In summary, we believe that many of the underlying issues and concerns identified in this proposed rule could be resolved more effectively with the

[1] 71 Fed. Reg. 4648, 4734, Table 24 (January 27, 2006).

implementation of clear, defined, transparent, and evidence-based admission criteria. We believe that all parties should work together to accelerate the process to develop and implement these admission criteria. We stand ready to work with CMS and other LTCH providers to achieve this critically important objective.

SPECIFIC COMMENTS ON THE PROPOSED RULE

I. Proposed Changes to LTCH PPS Payment Rates for the 2007 LTCH PPS Rate Year

A. LTCH PPS Market Basket

The NPRM proposes a new system to update the LTCH market basket called the RPL market basket, which will be based on the operating and capital cost of inpatient rehabilitation facilities, inpatient psychiatric facilities and LTCHs. The RPL would be based on FY 2002 cost report data versus the 1997 data used in previous calculations. Based on the 2002 data, the labor-related share is proposed to increase from 72.885 percent in RY 2006 to 75.923 in RY 2007. HealthSouth supports the use of an RPL market basket update process and would encourage CMS to utilize the most current available information to set LTCH payment rates in future periods.

The proposed rule indicates that the most recent estimate of the RPL market basket for July 1, 2006 through June 30, 2007 is 3.6 percent. However, the NPRM is "proposing a zero percent update to the LTCH PPS Federal rate for the 2007 LTCH PPS rate year rather than proposing an update based solely on the most recent estimate of the proposed LTCH PPS market basket as has been done in the past."[2] The NPRM cites increases in CMI, Medicare margins and patient census growth from the most recent LTCH data as the basis for a zero percent update factor for FY 2007. We do not believe this data supports a market basket freeze.

Historical experience with the development of other prospective payment systems (for example, acute care IPPS, IRF, and SNF) has shown that a certain degree of coding improvement following implementation of a new payment system is expected. As providers become proficient with new systems, coding accuracy improves. CMS has addressed this phenomenon in other PPS transitions through one-time payment adjustments. The adjustment made recently to the IRF PPS for FY 2006 is an example.[3] In the current NRPM, however, CMS has chosen to delay a targeted one-time adjustment pursuant to §412.523(d)(3) in favor of a zero percent market basket update. This is an inappropriate use of the market basket process and is inconsistent with the design of the LTCH PPS system.

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[2] 71 Fed. Reg. 4648, 4666 (January 27, 2006).

[3] 70 Fed. Reg. 47880 (August 15, 2005), made a 1.9 percent reduction to IRF payments.

These concerns are amplified by the fact that prior LTCH PPS adjustments have not been made on a budget-neutral basis. In the acute care IPPS rule published in the August 1, 2005 Federal Register,[4] LTCHs experienced a significant payment decline as a result of re-weighting and adjustments to the LTC-DRGs. This process has had the effect of adjusting for coding improvements and has not been taken into account in the current NPRM. Until the effects of these adjustments have been evaluated, it is premature to implement further payment reductions. CMS should provide the full market basket update for FY 2007 and make a separate determination of the need for a one-time adjustment after taking into account other re-weighting adjustments previously implemented.

The NPRM states that "we [CMS] believe a significant portion of the 6.75 percent increase in CMI between FY 2003 and FY 2004 is due to changes in coding practices rather than the treatment of more resource intensive patients,"[5] and that only 2.75 percent of this coding improvement relates to "real" CMI changes based on an increase in patient acuity. CMS concludes that "assuming that the "real" CMI increase observed (on average) from FY 2001 to FY 2003 remained relatively constant into FY 2005, then the difference of 4.0 percent (6.75 percent minus 2.75 percent) represents the "apparent" CMI increase due to improvement in documentation and coding. This is considerably higher than the 0.34 percent behavioral offset originally estimated by the CMS actuaries..."[8] We have conducted our own analysis of the Case Mix Index Trending from 2003 through 2005. Our findings show that from 2003-2004 and 2004-2005, HealthSouth's case mix index grew by 3.7% and 2.7%, respectively. This case mix index growth is completely attributable to a 63% and 11.3% increase in admission rates of high acuity respiratory patients over the same period. While we appreciate the difficulty in separately identifying "real" versus "apparent" CMI changes with full certainty, basing an adjustment of the magnitude proposed by the NPRM on assumptions that have not been verified by evidence is not appropriate.

LTCH margins continue to be a focus for both CMS and MedPAC. In its March 2006 report to Congress, MedPAC calculated Medicare margins at 5.4 percent for 2003, 9.0 percent for 2004, and an estimated 7.8 percent for 2006.[6] CMS estimates that LTCH Medicare margins for FY 2003 were 8.8 percent and estimates FY 2004 margins at 11.7 percent. Even under the CMS estimates, the roughly 15.0 percent "real' (i.e.., inflation adjusted) payment reduction proposed in the NPRM will drive Medicare payments to LTCHs substantially below the average cost of care for many providers (see Table 1).

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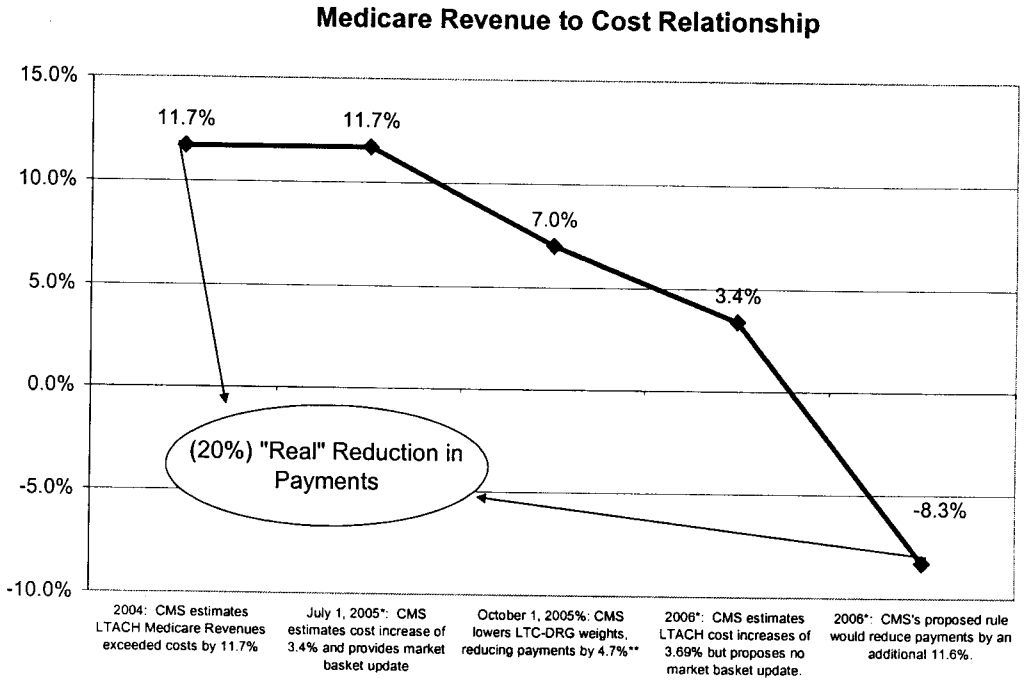
[4] Published in the Acute Care Hospital Inpatient Prospective Payment System Update for FY 2006.
[5] 71 Fed. Reg. 4648, 4668 (January 27, 2006).
[8] *Id.*
[6] March 2006 Report to the Congress: Medicare Payment Policy (March 1, 2006).



42 C.F.R. §413.89(d) is clear that the cost of treating Medicare patients should not be borne by other financial payers. The proposed rule would appear, on its face, to expect that other financial payers make up the shortfall in Medicare payments. It is not at all clear that they are prepared to do so.

Recommendation:

Medicare LTCH PPS payments should be set in a manner to ensure that the underlying cost of patient care does not exceed payments. We recommend that CMS provide a full market basket update for FY 2007 and develop a separate rulemaking to address issues with the underlying LTCH PPS.

B. Proposed Adjustment for High-Cost Outliers

The LTCH PPS authorizes additional payments for outlier cases that have extraordinarily high costs relative to the costs of most discharges. Consistent with previous rulemaking, the proposed rule sets the outlier threshold at a level to generate approximately 8 percent of total estimated payments under the LTCH PPS. The high-cost outlier threshold for RY 2007 is proposed to be increased from $10,501 (RY 2006) to $18,489. In RY 2006, CMS substantially reduced the outlier threshold amount because a portion of the 8 percent outlier funding was not being paid to providers. Now,

it appears, CMS is reversing its decision based upon the industry's expected reaction to the proposed SSO policy. According to the NPRM, the 76 percent increase in the outlier threshold amount is necessary to account for the reduction in overall LTCH payments caused by SSO payment policy revisions. The regulatory impact section of the proposed rule indicates "we [CMS] believe that if the proposed changes to the SSO are implemented, most LTCHs would substantially reduce the number of short-stay cases that they admit." The proposed rule appears to provide additional justification for the significant increase by comparing the proposed threshold to amounts in FY 2003 ($24,450), RY 2004 ($19,590), and RY 2005 ($17,864). There is no evidence that LTCH's possess the foresight to accurately predict either the length of stay at the time of admission or the changes to a patient's condition occuring during the stay, which would reduce the number of short-stay cases admitted to the hospital. Since providers are not able to predict which admissions will be short-stay cases, the number of short-stay cases to be eliminated by the SSO policy change is difficult, if not impossible, to predict. Similarly, the amount of the 8 percent outlier set-aside actually paid to providers is difficult to estimate. Given these uncertainties, we believe a more moderate increase in the high cost outlier threshold is warranted.

Recommendation

CMS should recalculate the high cost outlier threshold, taking into account previous rule-makings and other payment policy changes made from this proposed rule to ensure that the entire 8 percent pool of outlier funds is expended on LTCH high cost cases.

C. Proposed Budget Neutrality Offset To Account for the Transition Methodology

The proposed rule frequently cites the broad authority conferred upon the Secretary by section 123 of the Balanced Budget Refinement Act of 1999 (as amended by section 307 (b) of Benefits Improvement and Protection Act of 2000) to develop the LTCH PPS, which confers responsibility to maintain budget neutrality. The NPRM removes over 11 percent of SSO payments and proposes to implement an additional 0.1 percent reduction (budget neutrality offset of 0.999) to all LTCH payments for discharges occurring on or after July 1, 2006 and through June 30, 2007, to account for the estimated cost of the transition period methodology. We anticipated a positive budget neutrality adjustment.

Recommendation

CMS should re-evaluate the budget neutrality adjustment after considering other comments responding to the NPRM. Any budget neutrality adjustment in FY 2007 should be positive if other payment reductions included in the proposed rule are put into effect.

D. One-Time Prospective Adjustment to the Standard Federal Rate

Under previous rule-making implemented by 42 C.F.R. §412.523(d)(3), CMS reserved the authority to make a one-time prospective adjustment to LTCH rates by October 1, 2006, so the effect of any significant difference between actual and estimated payments for the first year of LTCH PPS would not be incorporated in future rates. In fact, however, the changes proposed in the NPRM will have the same effect on payment rates as a one-time adjustment.

Regardless of whether a look-back is necessary and consistent with other prospective payment systems, an adjustment should be made once and not used as a basis for other policy decisions, such as reductions in market basket updates. The proposed rule indicates that 98 percent of all LTCHs have already converted to 100 percent of the federal rate. Any future analysis would not be statistically significant with the inclusion of the remaining 2 percent of facilities still receiving transition payments. As such, CMS currently has sufficient data to properly compare payment levels both pre and post implementation of the LTCH PPS. This data should be used to make any adjustment necessary in RY 2007 wholly independent from annual market basket calculations.

Recommendation

Consistent with our recommendations under the market basket update, CMS should pursue a one-time adjustment afforded under 42 C.F.R. §412.523(d)(3), independent of a market basket update for FY 2007.

II. Other Proposed Policy Changes for the 2007 LTCH PPS Rate Year

A. Adjustment for SSO Cases

The current SSO policy has been in place since the inception of the LTCH PPS, and the proposed changes are surprising, given CMS's historical treatment of this policy. Upon implementation of the LTCH PPS, CMS noted that roughly 48 percent of LTCH admissions resulted in an SSO payment. This percentage has been reduced to 37 percent based on the most recent analysis of the 2004 MedPAR file. An 11 percent reduction in SSO cases is significant and seems to indicate that the LTCH PPS is having the desired effect of reducing short stay cases. We also note that our own mix of 2005 SSO cases is noticeably below the national average, at approximately 29 percent. When all of the trends confirm that the LTCH PPS is maturing in a manner consistent with congressional expectations, we belive these drastic proposed changes to SSO policies are not required at this time.

The fundamental flaw in the proposed SSO policy changes is the assumption that LTCH providers can differentiate at the time of admission the range of care and services needed to treat a patient, the complexity of the treatment plan, or the ultimate outcome of the case. LTCH providers are unable to reliably predict **prior to admission** the number

of days for each stay, whether the stay will result in mortality, and whether additional complications may arise during the stay. While modern medicine may provide certain probabilities for each of these unknowns, there is no uniform evidence tool or set of protocols published that would enable LTCH providers to know these answers **for a particular patient** at the time of admission.

In most cases, an LTCH is contacted by an acute care hospital's discharge planner (the chief source of LTCH referrals) when the hospital and the patient's physician believe the patient is appropriate for discharge to the LTCH setting. LTCHs screen these prospective patients against established admission criteria developed individually by each LTCH due to the absence of standardized, established admission criteria. Contrary to much of the proposed rule's discussion, patients are admitted only when it is deemed that an LTCH stay has a high probability of returning the patient to a higher level of functionality.

Current medical knowledge does not permit an LTCH to identify SSO cases at the time of admission so as to deny their admission – as apparently contemplated by CMS in the proposed rule. Cases that are appropriate for LTCH care should be admitted to an LTCH, and the operation of the current SSO policy ensures that Medicare payment for the SSO case is appropriately reduced to account for the reduced level of services furnished during the shorter stay.

Evidence-based research has established that LTCH patients have significantly higher Severity of Illness (SOI) scores than similar acute care hospital patients. These LTCH patients tend to have a level 3 or 4 SOI score under APR-DRGs. Congress authorized a separate payment system for LTCHs to provide coverage for medically complex cases requiring a longer hospital stay. An underlying theme throughout this proposed rule is the assumption that LTCHs are deliberately admitting a high percentage of inappropriate patients. Although we understand the need to evaluate the growth experienced in the LTCH industry, we strongly disagree with the assumption that LTCHs are purposefully admitting inappropriate patients. We join MedPAC, CMS and our LTCH provider colleagues in supporting the adoption of uniform, evidence-based LTCH patient admission criteria. The development of these criteria will provide a far more effective, long term solution to many of the concerns identified in the NPRM. The development of these criteria is a better policy approach than trying to address the issue of growth and appropriate admissions through payment reduction policies.

The LTCH PPS design, like every PPS, must continue to be an economically efficient payment system. Any changes to the underlying PPS framework should result in policies that will permit its explanatory power and long-term validity to be maintained. However, the proposed SSO policy change will create substantial inequities in the LTCH PPS. The proposed changes ignore the averaging approach that underlies all prospective payment systems, by deliberately underpaying cases that are discharged prior to the full GM LOS. In the original development of the LTCH PPS, CMS "found that five-sixths of the geometric average length of stay would be the short-stay outlier threshold where the

full LTC-DRG payment would be made at 120 percent. That is, by adjusting the per discharge payment by paying at 120 percent of the per diem DRG payment, once a stay reaches five-sixths of the geometric average length of stay for the LTC-DRG, the full DRG payment will be made."[7] This SSO threshold was set in a manner that ensured each LTC-DRG avoided a payment cliff between the day prior and the day of reaching the full LTC-DRG payment. By contrast, the new proposed SSO payment policy will create a substantial "payment cliff" between the full LTC-DRG payment and the SSO payment. Examples of this "payment cliff" can be seen in the sample LTC-DRG cases shown in Table 2. These payment differentials undermine the basic logic of the LTCH PPS.

Table 2 – SSO to Comparable Acute Care Payment Comparison

LTC-DRG	Full LTC-DRG Payment	120% LTC-DRG Per Diem Payment (5/6th GLOS - 1 Day)	Acute IPPS Payment	Difference - Payment Cliff Uncompensated Care (2)	LTC-DRG 5/6th GLOS	Acute DRG GLOS	Difference - LTC-DRG 5/6th GLOS and Acute DRG GLOS (3)
249	23,979	22,834	3,485	(19,349)	20.6	2.7	(17.9)
012	24,978	23,861	4,419	(19,442)	21.3	4.3	(17.0)
087	39,434	37,633	6,706	(30,927)	21.2	4.9	(16.3)
466	24,307	23,042	3,834	(19,208)	18.3	2.8	(15.5)
088	24,008	22,489	4,311	(18,178)	16.3	4.0	(12.3)
127	25,000	23,632	5,081	(18,551)	17.7	4.1	(13.6)
462	21,099	20,006	4,273	(15,733)	18.7	8.9	(9.8)
475	75,948	73,226	17,726	(55,500)	28.8	8.1	(20.7)
089	25,474	23,955	5,069	(18,887)	17.3	4.7	(12.6)
316	29,966	28,355	6,234	(22,122)	18.9	4.9	(14.0)

1 Table 2 summarizes approximate payments from our LTCH hospital in Harrisburg, PA.
2 Calculates difference in LTC-DRG 120% Per Diem payment at one-day shy of the full LTC-DRG payment and the comparable Acute Care IPPS payment amount.
3 Demonstrates on average the LOS that is not factored into the payment formula and LTCHs will have to render Uncompensated care.

Table 2 demonstrates the substantial payment cliff that will occur if the proposed SSO policy is implemented. LTCHs will be expected to treat cases that are, on average, $15,000 to $55,000 below current payment levels. This substantial change will undermine the integrity of the LTCH PPS.

The proposed rule concludes that LTCHs will react to the SSO policy by admitting fewer cases. In light of the difference in payment between SSO payments and the full LTC-DRG, we note that the proposed changes may introduce different and

[7] 67 Fed.Reg. 55953, 55997 (August 30, 2002).

perhaps unanticipated incentives for LTCH providers. The magnitude of the SSO policy changes may encourage LTCHs to keep patients longer in order to meet the GM LOS requirement. Indeed, CMS discussed this very concern in the FY 06 LTCH final rule published in May 2005.[9]

> We continue to be concerned that our policies must assure that LTCHs only treat patients for whom the LTCH level of care is appropriate in order to ensure that Medicare is a prudent purchaser of these very costly services. In addressing one aspect of the issue of whether patients in LTCHs truly need hospital-level of care, beginning in October 2004 and slated to end in July 2005 OCSQ has undertaken a study of LTCH short-stay outliers. Under the short-stay outlier policy at Sec. 412.529, when a LTCH patient stay is considered a short-stay outlier for Medicare payment purposes, the LTCH receives an adjusted (generally lower) payment when the covered days of care do not exceed five-sixths of the (geometric) average length of stay for the particular LTC-DRG assigned to the case. The study evaluates the extent of short-stay outliers and the possibility of retention of patients by the LTCH when the LTCH patient no longer requires hospital-level of care and could be effectively served in a SNF. Due to possible reductions in payment combined with a need to maintain an average length of stay of greater than 25 days to remain an LTCH, we believe that LTCHs may be retaining these patients beyond the short-stay outlier threshold in order to increase Medicare payments. The three QIOs located in States which house the majority of LTCHs are conducting reviews on six months of records from the monthly random sample for this study in order to assess this situation and to determine whether and to what extent patients are being retained at the LTCH beyond their need for hospital-level care and whether retention can be linked to the increased payment for patients exceeding the short-stay outlier threshold. If it is determined that retaining LTCH patients unnecessarily beyond the short-stay outlier threshold is a significant payment issue, OCSQ plans to add this review type to the standard QIO LTCH review.

The LTCH PPS design must continue to provide appropriate incentives and rewards for high-quality, cost-effective patient care. The proposed SSO policy will not result in an effective and efficient system in RY 2007 and beyond.

At the inception of the LTCH PPS, CMS proposed to have a separate payment threshold for cases lasting 7 days or fewer. This policy was abandoned "to eliminate the incentive for LTCHs to keep patients additional days simply to receive the monetary windfall that occurs with a payment "cliff."[9] We understand that CMS is particularly concerned with cases that end in mortality or are

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[8] 70 Fed. Reg. 24,168 (May 6, 2005).
[9] 67 Fed. Reg. 55954, 56001 (August 30, 2002).

discharged to another setting after 7 or fewer days. To this end, we support the development of a new payment methodology for these very short stay cases lasting 7 or fewer days. Specifically, we propose that these cases should be paid the lesser of:

1. 100 percent of the cost of the case; or
2. 100 percent of the LTC-DRG per diem payments.

This policy would ensure that at no time would Medicare reimburse the provider in excess of the cost of the case. This methodology is similar to the methodology applied to acute care hospital transfers. It would not create incentives for providers to extend the stay to qualify for the SSO payment, as the payment cliff or windfall would be insubstantial. We propose that the existing SSO policy remain for stays greater than 7 days up to the five-sixths of the GM LOS. We do not recommend any specific policy relating to cases that end in mortality. Based upon a review of cases ending with this outcome, we have been unable to detect any evidence-based correlation or relationship between mortality associated with a very short stay (day 0 to 7), SSO period (day 8 to five-sixths of the GM LOS) or the full LTC-DRG. As such, we believe a penalty-based policy for mortality would not be appropriate.

We acknowledge the challenges confronting CMS in developing a sound payment policy to protect the Medicare Trust Fund. However, certain major tenets should be observed when considering adjustments to the LTCH PPS design. First, adjustments should not compromise quality of care provided by LTCHs or limit access to patients needing their services. Second, the payment system should reward providers that provide high-quality, cost-efficient care to Medicare beneficiaries. Third, adjustments should not undermine the predictive power of the PPS or its efficiency in tying payments to actual service costs. Fourth, the payment system should remain as uncomplicated and transparent as possible to providers. Fifth, with the exception of very high-cost outliers, payment policy should never result in payment below the cost of the case. Finally, the system should permit providers to achieve reasonable margins as a basis for implementing new technologies and replacing or renovating existing physical plant and equipment.

While we understand that small adjustments may be needed to deal with certain very short stay cases, concerns with overall LTCH growth are more appropriately addressed through the development and implementation of uniform, evidence-based patient admission criteria.

Recommendation

We recommend that the proposed SSO policy be amended to implement a very short stay policy for LTCH discharges occurring in the first 7 or fewer days of the stay. Payment for these very short stay cases would be paid at the lower of 100

percent of the cost of the case or 100 percent of the LTC-DRG per diem times the days of care rendered. The current SSO policy should remain in effect for discharges occurring between days 8 up to five-sixths of the GM LOS for each LTC-DRG.

B. Interrupted Stays of 3 Days or Less

The proposed rule would not renew the surgical-DRG exception for interrupted stays of 3 days or less for LTCH PPS RY 2007. With the termination of this exception, treatment at an acute care hospital that was grouped to a surgical DRG would be considered part of the LTCH stay and paid for by the LTCH "under arrangement." While we agree that the amounts presented in the NPRM for the one-year period July 1, 2004 through June 30, 2005 are not significant, we offer three observations. First, in the original development of the Standard Federal rate for the LTCH PPS, the cost of these acute care surgical procedures was not included in the initial payment rate. Second, the proposal to end the exception is based on only one year of data. Third, the surgical procedures are not built into the current relative weights, as coding for this care was never historically included by most LTCHs. We recommend that CMS study this provision more thoroughly and consider making a one-time adjustment to the Standard Federal rate to account for the additional cost of paying for these cases under arrangement. No data has been provided in the proposed rule to support the premise that coding the surgical procedures on the LTCH claim will result in higher payment to cover this additional cost. We are further concerned that this policy could reduce access to care if patients are not readmitted to the discharging LTCH.

Recommendation

CMS should postpone its action related to the termination of the surgical DRG exception or make a one-time adjustment to include this additional cost to pay for these services "under arrangement" in the Standard Federal rate.

C. Special Payment Provisions for LTCH Hospitals Within Hospitals and LTCH Satellites

The proposed rule has articulated many concerns with both freestanding and hospitall-within-hospital ("HIH") LTCHs. At the center of these concerns are: 1) a view that most if not all LTCHs are operating as a "unit" of host acute care hospitals; 2) that LTCHs may be inappropriately shifting patients to circumvent the new HIH criteria at 42 C.F.R. §412.534; and, 3) the underlying growth of LTCHs in general. While the proposed rule does not introduce any new policy directives in these specific areas, we believe it is important to address each of these concerns as CMS contemplates further rulemaking.

CMS has introduced multiple policies over the years to address HIH relationships. The intent of these regulations was to remove financial incentives for the HIH LTCHs to

operate, in effect, as a "unit" of the acute care hospital. Most recently, CMS has introduced two rule changes that were directed at removing financial incentives for early discharge to an LTCH. Specifically, CMS has implemented new HIH LTCH criteria at 42 C.F.R. §412.534 that will limit (after a phase-in period) the percentage of patients that may be admitted from the host acute care hospital. Additionally, CMS has also expanded the number of post acute care discharge DRGs (182) subjected to a transfer payment policy in the acute care hospital setting.[10] Both of these policies have been designed to remove incentives from both the referring host hospital and the receiving LTCH. Although neither of these policies have been in place for a sufficient time to evaluate their effects, we firmly believe they will limit the number of HIH LTCHs.

The premise that freestanding LTCHs are acting as "apparent units" or lacking "functional separateness" is not supported in the marketplace, nor would a similar evaluation with other post-acute care industries yield significantly different results. It is well established that LTCHs receive a majority of their admissions from acute care hospitals. These admissions occur only when the acute care hospital, in conjunction with the patient's physician and the patient/family, determine based on the patients' medical condition that the patient should be transferred to an LTCH. We see no evidence that physicians are prematurely discharging patients to LTCHs on a systemic basis. Second, CMS focuses on the fact that a significant percentage of patients may be received from one or two closely located acute care hospitals. This is consistent with the notion that patients and physicians utilize services in close proximity to the patient's homes. This geographical proximity enhances the quality of patient care by allowing physicians quick access to their patients needs. The admission percentages in all post-acute care settings will have a direct correlation to the number and proximity of acute care providers in the market area. Health care decisions are made by the patient and the patient's physician.

We see no linkage supporting the notion that acute care hospitals and LTCHs are herding patients to maximize payment. Our LTCH locations were established and continue to operate at arms-length from all our referring acute care hospitals. Furthermore, there is no precedent to support the position that the number of admissions is appropriate at or below 25 percent from a particular referral source. Establishing an arbitrary limit without regard to local conditions may seriously compromise access to care in many communities. Such a policy would very likely have serious consequences for access to LTCH care in many rural or other non-urban communities where a small LTCH facility may not have 7 or 8 large acute care hospitals from which to draw medically appropriate patients. CMS should give this concept a great deal of additional study.

We are equally concerned with the assertion that LTCHs may be inappropriately shifting patients to circumvent the HIH requirements. We agree that hospitals that are engaged in inappropriate practices should be reviewed and penalized. However, anecdotal allegations of misconduct are not an appropriate foundation for broad payment

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[10] 70 Fed. Reg. 47278 (August 12, 2005).

policy changes. If these are legitimate areas of concern, we recommend that CMS work with the Office of Inspector General to determine the scope of the problem and to determine the effectiveness of new fraud alerts or other more specific enforcement actions.

Recommendation

Concerns with the growth and proliferation of LTCH services can best be addressed by the implementation of uniform, evidence-based patient admission criteria. Growth in the LTCH industry will occur based on the demographic make-up and numbers of covered Medicare beneficiaries needing LTCH level of care in coming years. Attempting to manage that growth through drastic and unpredictable payment reductions will not be effective in separating patients who require an LTCH level of care from those who do not, but instead risks undermining the long run integrity and effectiveness of the LTCH PPS system.

III. RTI Report on MedPAC June 2004 LTCH Recommendations

CMS contracted with RTI to examine the feasibility of implementing MedPAC's recommendations to define LTCHs by facility and patient criteria. Although some of the preliminary findings of the RTI study are discussed in the proposed rule, the study is not yet final and a complete response to what is partially known about its status is not possible. Once the RTI study is complete, we hope its findings and data will provide a framework upon which appropriate admission criteria can be developed and used to distinguish the types of patients who require the care and services of LTCHs.

As has been noted elsewhere in these comments, HealthSouth believes that appropriate LTCH criteria can and should be developed, and we look forward to working with CMS and others in their development and implementation. The implementation of appropriate LTCH criteria will affect a range of behaviors and policies within LTCH hospitals, including patient admission practices. It may even result in a reduction in the number of short stay LTCH admissions. The preliminary RTI analyses raise questions which require further review and discussion among medical and policy experts before many of the policy changes included in the proposed rule are implemented.

A. More Evidence Is Needed To Determine If Diagnostic Groups Alone Can Sufficiently Define LTCH Patient Populations

Preliminary findings from the RTI study suggest more evidence is needed to determine if diagnostic groups alone can sufficiently define patient populations that are most appropriate for an LTCH level of care, versus acute care outliers and other post-acute care settings, such as inpatient rehabilitation or skilled nursing. We agree that focusing on diagnostic groups is an important element in defining a patient population. However, the RTI study demonstrates that there are clinical variations within single

diagnostic groups or DRGs. This is an important finding, and may support the premise that within a specific patient population there are subsets or groups of patients who can be clustered differently for purposes of more accurately determining which levels of care are most appropriate for their medical needs. RTI provided several examples demonstrating how single clinical conditions or DRGs can be further sub-categorized for purposes of demonstrating level of care placement.

For example, RTI found that DRG 475 (Respiratory System Diagnosis with Ventilator Support) was often associated with pneumonia related or chronic bronchitis among acute care outlier patients. By contrast, the same DRG occurring in an LTCH setting represented a subset of conditions, such as "other lung disease", i.e., pulmonary collapse, emphysema, acute edema, etc.[10] Similarly, RTI found that for DRG 249 (Aftercare, Musculoskeletal System and Connective Tissue), there were clinical subsets that differed across settings of care. In LTCHs and SNFs, DRG 249 represented "other orthopedic aftercare" (which included, for example, the removal of fracture plate, pins, rods, screws and the aftercare for healing traumatic or pathologic fractures). By contrast, the acute care and inpatient rehabilitation patient populations represented by this DRG were more likely to be treated for replacement and graft-related complication. These examples provide new evidence suggesting that within a DRG there are subsets of clinical conditions that, with sufficient refinement, could be precisely categorized and used to distinguish the need for an LTCH level of care or other level of care, such as acute care outlier, inpatient rehabilitation, or skilled nursing. Further research should be done in this area.

B. The Need For Severity Measures Across Various Levels Of Care

The inclusion of a measure of severity based on comorbid conditions is an important concept, because it recognizes additional medical conditions that require ongoing medical management and thus contributes to the overall medical complexity of cases admitted to a post-acute hospital level of care. Although there are various tools for measuring severity, we believe a standardized tool, such as the Charlson Index, could be used to further study a severity measure based on comorbid conditions in acute care outliers, LTCH, IRF and SNF levels of care for certain subsets of patient populations. Results of such studies would most likely contribute to better identification of the unique characteristics of a population that are best served at a certain level of care.

In addition, RTI also noted that little is known about the differences in severity across different settings of care, since functional independence measures (FIM scores) are only collected in IRF settings. This is an important observation, and implicitly underscores the need for a standardized tool that can be used across various levels of care to measure function as a measure of patient severity. In addition, subsets of patient

[10] 71 Fed. Reg. 4648, 4710-11 (Jan. 27, 2006).

populations may be better served at one level of care versus another, using severity of comorbid conditions to better describe the medical complexity of the case. Function should be included as a measure of severity to understand the improvement or decline of patients, and to better understand why patient populations are served at various levels of care.

A major challenge in determining severity based on functional levels is the lack of one standardized tool that can be used in multiple care settings. Information from functional scores based on a standardized severity measurement instrument would provide a more complete explanation of the resources needed in providing sufficient care and the burden of care based on function. Together, functional severity as well as comorbid severity measures could be used to construct meaningful subgroups within patient populations to better identify similarities and differences relative to their care needs.

RTI is continuing to seek input from clinicians with the objective of developing recommendations to CMS regarding a patient assessment instrument for LTCHs. We believe that it would be prudent to delay many of the payment policy changes included in the proposed rule to allow sufficient time for the development of uniform, evidence-based LTCH patient admissions criteria.

IV. Regulatory Analysis

The Regulatory Flexibility Act ("RFA") requires CMS to analyze the impact this NPRM will have on small businesses. It is clear that most if not all LTCHs would be considered small businesses under the RFA. Further, this proposed rule is projected to reduce overall LTCH payments by over 11%, or $362 million. The NPRM certifies that this proposed rule would not have a significant impact on a substantial number of small entities, in accordance with the RFA. This certification is based on the assumption that LTCHs can tell at the time of admission which cases will result in a full course of treatment versus those that will stay for less than 5/6ths of the GM LOS. The general belief in this proposed rule is that the industry will remediate this material reduction in payments by decreasing SSO admissions, thus reducing the overall impact on LTCHs. We are not convinced that this can be done.

CMS has not put forth any tested, evidence-based protocols that would assist in making these determinations. We believe that a complete analysis under the RFA needs to be conducted prior to issuance of a final RY 2007 LTCH PPS rule.

Recommendation

Prior to issuance of the RY 2007 LTCH final rule, CMS should conduct a complete analysis under the RFA.

V. Appendix A—Description of a Preliminary Model of an Update Framework under the LTCH PPS

HealthSouth understands CMS' desire to improve the underlying framework that would update payments to LTCHs in a manner that positively affects the efficient delivery of healthcare services for Medicare beneficiaries. We believe that any change to the underlying market basket update framework should provide LTCHs with a predictable methodology for updating payments, keep pace with increasing costs of providing patient care and allow for adequate margins to replace and update hospital infrastructure and physical plants. An effective framework should also reward LTCHs that deliver high quality, cost-effective patient care.

Given the complexity of the conceptual ideas put forth by CMS for updating the LTCH payments discussed in this proposed rule and the limited time afforded to comment on the entire rule, HealthSouth respectfully asks CMS to extend the timeframe in which it will accept comments on this issue. We also ask CMS to be open to working with all industry stakeholders in the development of this revised framework to update LTCH payments.

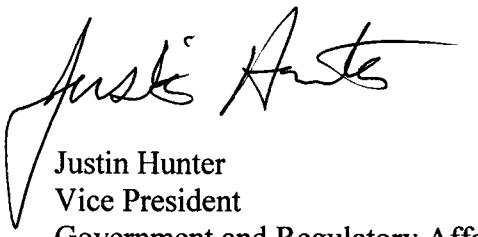
Conclusion

A prospective payment system should be designed to promote equal access to, and payment for, medically appropriate care received by patients with comparable conditions and treatment needs. Any changes to the underlying design should not take away from the long-term validity and explanatory power of its framework. We believe that the proposed changes that are being contemplated for SSO cases will undermine the basic integrity of the LTCH PPS framework. It will force physicians and providers to attempt to ration access to LTCH services without the benefit of evidence-based evidence protocols. *In fact, the standard LTCH admission tools most widely in use today would support the admission of most if not all of these SSO cases.*

We believe that CMS should abandon the SSO payment adjustments being proposed or, at a minimum, consider the more modest reforms described in these comments for very short stays. CMS should accelerate the development of uniform, evidence-based patient admission criteria. The pending RTI study should provide a framework for this effort. We stand ready to work with CMS and other LTCH providers to use the RTI findings, as well as other available data and evidence, to develop effective LTCH admission criteria on an expedited schedule.

HealthSouth appreciates the opportunity to comment on this proposed rulemaking.

Sincerely yours,



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